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INTERDISCIPLINARY HEALTH CARE TEAMS:
INTERNAL POWER ISSUES

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As a member of an interdisciplinary geriatric health care team for six years,* this author had an opportunity to observe internal team functions during various team stages (formation - termination) of a team which went through nine distinct phases. Some team members remained constant for almost all nine phases while others changed.

The complex environment in which the team existed was a grant funded by the Veterans Administration, administered by the University, and which functioned in a VA clinical setting with VA patients and university students. The team was heavily influenced by the adjoining university setting as most team members were hired by the university. Several members had joint appointments and, later in the Grant, some members were solely VA employees. These two organizational entities had major impacts on the team at various times throughout the seven years. With few exceptions, the local VA environment was initially hostile. But as the years went by, some functions became extremely supportive and others tolerant. The team was not viewed as a power entity within its organizational environment. Only in the final six months of the grant did the team members view the team as having some limited power in relation to its external environment. While the issue of external power is important, the focus of this paper will be on the exercise of power within the team itself.

The purpose of this paper is to define power and the related term of control in the context of its application with interdisciplinary teams. This paper will attempt to identify and analyze situations where power has been used within a functioning interdisciplinary clinical team. An analysis of some of those situations and interviews with team members reveal several variables surrounding outcomes of intentional and unintentional application of power strategies.

INTERDISCIPLINARY

Interdisciplinary teams as they are used in health care settings are groups of professionals who work together in an interdependent manner, either with complex patients or complex problems. When functioning effectively, their raison d'etre is an end product more comprehensive than that provided by an individual. There are many misconceptions re: interdisciplinary teams; and disagreements about the general definition of interdisciplinary teams. They have been

*The team was authorized under a seven-year Veterans Administration Interdisciplinary Manpower Training Grant which was administered by a local university. A team was not formed until the second year of the grant.

equated with work groups, i.e., a group of more than two professionals working together. This tends to be the definition most often used by physicians. However, "interdisciplinary teams cannot be equated with work groups in general, since the establishment of an interdisciplinary team specifically implies that close and continuous collaboration of people with different skills and professional identification appear necessary." (Horowitz, p. 59) Collaboration is based upon equality between parties re: problem definition and solutions. Since M.D.'s are the profession with the highest status, they have the most to lose in the collaborative relationship which must be part of a functional interdisciplinary team.

Horowitz goes on to say that team members must be committed to risk collegial criticism in a "continuous give-and-take dedicated to the improvement of what is seen as a common enterprise." He also notes the importance of participation in the form of discussion. When professionals contribute additive pieces which make up a whole, they are not engaged in discussion. "A sharing of insights regarding the picture overall is an essential of true discussion." (p. 60)

The Center for Interdisciplinary Education in Allied Health at the University of Kentucky defines interdisciplinary in this way:

A process where the solution of problems or completion of tasks requires the interdependent talents of different people. If I can do the task or solve the problem alone, then my actions are not interdisciplinary. If a task can be divided into two parts and you and I can each solve our parts alone, the process is multidisciplinary. If you and I need to work on a task together but are each using the same skills, then the task is monodisciplinary, and two people can just get the job done faster. But, if you and I must work together, each contributing different skills to the task and our individual skills are both needed to complete the task, then we are interdependent and interdisciplinary.

A necessary change in this definition from Horowitz's discussion.

If you and I must work together, each contributing different skills to the task, and our individual skills are both needed to complete the task, then we are interdependent. If we engage in true discussion, a sharing of insights regarding the overall picture, and make a decision based on those insights, we are also interdisciplinary.

Individual competence in respective professions is the technology brought to the interdisciplinary team. Technology is the mechanism to transform inputs to outputs; on an interdisciplinary team an added dimension to the individual skills of the members is the interaction of the knowledge and skills of all the team members. This is what often creates higher level solutions to patients' problems. Because a key factor in interdisciplinary teams is interdependence by means of interpersonal interactions, internal functioning takes on major importance. The two subgroups encompassed by the term 'internal

team functioning' are Structure and Process. Some common examples of Structure and Process within interdisciplinary team functions are:

<u>Structure</u>	<u>Process</u>
Formal authority (director)	Goal setting
Leadership	Problem-solving
Norms	Decision making
Composition	Communicating
Formal professional role	Managing conflict
Atmosphere (team spirit)	Agenda setting
Professional status	Informal role negotiating
Physical placement	(informal authority and status)
	Influencing
	Trust building

Among Process items absent from this list are exercising power and control. Cartwright, one of the more eminent group theorists, has accused group psychology of being 'soft on Power' (p. 96). In his article, "Power Theory and Institutional Change", John Wax relates that power has been a dirty word in our history since Lord Acton said, "Power corrupts, and absolute power corrupts absolutely." He goes on to note that in the sphere of activities surrounding "social change" in the early 70's, power became respectable and fashionable (p. 274). While it may have become fashionable in group literature it is not so in interdisciplinary literature.

The literature on interdisciplinary teams is full of references to Role, Status, Influence, and Leadership with their implications for interdisciplinary team process. The terms Power and Control are occasionally used with reference to "inter" or external team contacts but are rarely used in reference to "intra" or internal team functions.

POWER

Most texts on interdisciplinary teamwork virtually ignore the issue of power. In Gray and Nichols (p. 4), 'power is listed under 'individual drives and motivations'. In Ducanis and Golin (pp. 122-125), 'power' is honored by a few paragraphs sandwiched between 'Role and Status' and 'Leadership'.

Because power refers to the extent that one person can alter another's behavior in a manner which would not otherwise take place (Dahl, p. 202-203), it is usually seen as an alien element to the preferred decision-making mode of the functional interdisciplinary team, i.e., interdependent collaboration. Team and particularly interdisciplinary team literature, tends to emphasize team process functions where everyone "should" be equal, i.e., have the same amount of influence for decision making. Power is negated and thus ignored, or at least tiptoed around, while the more comfortable related issues of role negotiation, influence, and leadership are addressed. Despite the neglect of power issues, the power strategy of collaboration, as a mechanism for team member interaction, is assumed.

Collaboration implies mutually held goals and some perception of personal equality. Ducanis and Golin note that role and status relate to social power (p. 122). Thus, a team member with an important professional role, whether socially, organizationally, or technologically, such as a physician on a health care team, who has high professional status (physicians traditionally have higher status than any allied health professions) would enter a team with a high degree of social power.

While collaboration is the ideal, is it always feasible? Good team process should lead to collaboration but what power currencies are used within those process functions? Even when collaboration is used in team decision making, does it have to be used in other team interactions? Do other power strategies, such as negotiation or coercion, always adversely affect the team function?

French and Raven (1959) have looked at small groups and identified five bases of power: reward power, coercive power, legitimate power, referent power, and expert power. John Wax, in a discussion of power within alliances, notes that "the ability to reward and punish is a basic requisite of power" (p. 280). Within the interdisciplinary team rewards and punishments often are conferred and experienced between individual team members. Rewards are usually in the form of support or praise, and punishment is not punishment per se but a withholding or withdrawal of these rewards. Collins and Guetzkow (p. 139) propose that control of rewards associated with 'friendly interaction' is a source of power. Control of punishment is a source of power but it will not lead to interpersonal liking and will inhibit the exercise of power based on interpersonal attraction.

As they participate in the sharing of insights, each bit of work or insight of a team member has potential for being facilitated or impeded by the activities of other team members. Even though the individually mediated rewards and negative reinforcements do not seem to be the central means of control within the team, this ability to facilitate or impede might be the nucleus of the power which is pervasive within functioning and malfunctioning interdisciplinary teams.

CONTROL

Control is closely related to the element of power and it too is seldom mentioned in interdisciplinary literature. Webster defines the verb control: a) "to exercise restraining or directing influence", b) "to have power over". A controller is defined as, "one that controls or has power or authority to control."

The need for control within the work environment is addressed both directly and indirectly in literature on the "burnout phenomenon". Pitches are made to administrators to help staff "feel" they are being heard. Staff participation in decision making is strongly encouraged. Depressed patients often say they feel out of control. And self-management (control) techniques are taught in the psychotherapies for depression. Participation in clinical professional decision making is

a means that all interdisciplinary team members have to exercise control. Collins and Guetzkow propose that direct control of task-environmental rewards and control of the rewards associated with "friendly interaction" are both sources of power (p. 139). If a professional has information which will impact on a patient's care and the goal of the team is to make the patient better, then that professional has control over task-environmental rewards. You have all met people who control their friendly interactions. Some questions to consider: Are these the central elements of control in an interdisciplinary team? Do only a few team members exercise these control mechanisms? Are they exercised by all team members? Or do only the most powerful team members exercise these mechanisms? Certainly the amount of control team members require is dependent on their individual need for power and their role expectations. Some team members may not desire the responsibility of power. The control some team members actually have, might be dependent on having their mechanisms of control accepted by other team members.

However, in terms of interdisciplinary functioning the most central question remains: Where is the most significant internal control held?

TEAM'S PERCEPTIONS OF POWER

During the seven years of the Grant's existence there were nine "phases" of the interdisciplinary team. A new "phase" is designated for each time significant team members left or there was a strategic organizational decision having a major impact on the grant. Members were on the Team for lengths of time varying from several months to $6\frac{1}{2}$ years. Except for medicine, nursing, and occasionally social work, there was normally one representative from each discipline (although some semesters not all disciplines were represented). (See Appendix A.)

Of the 34 past and current team members, 26 could be considered to have been involved to a degree that would enable them to form an opinion of its internal functioning. Of these 26 team members, 13 were accessible to this author for individual unstructured interviews. They were all told that the purpose of the interview was to identify power issues which have existed within the nine team phases. Only one of those interviewed asked for a definition of power. All seemed to be aware of its existence within the team. The team member who requested the definition did not feel comfortable discussing the issue of power within the "team" with this author. Of the others who were interviewed all appeared comfortable sharing their opinions. There seemed to be a positive correlation with the amount of time spent on the team to the amount interviewees wished to contribute.

Four questions were asked of all team members interviewed:

- 1) Whom do you see as having power on this team or past teams?
- 2) What do you do (did you do) if you want (wanted) the team to agree to something or to do something?
- 3) In any given phase, who had the least power on the team?
- 4) Do you (did you) have power within the team? What kind of power?

Responses to these questions were many and varied.

Responses to question 1 ranged from "no one" to "everyone". Responses most frequently referred to the "Primary Care Team", i.e., the nurse practitioner, social worker, or physician within any team phase.

The most frequent response to question 2 was "I bounce it off the most knowledgeable team member first." Other responses were: "It depends on the issue"; "When there is a problem with a team member I build a power base, whereas when there is an issue to be decided I go directly to the team"; "I bring it up to the team and explain the rationale". Many members stated that they did not feel comfortable bringing issues directly to the team for several months to more than a year after they had joined the team. This did not seem to correlate with any particular profession. Team members noted that they had difficulty at first identifying the "right people" to go to re: a given issue. Some members also noted that it was frightening at first to get involved on the team because of "a fear of losing part of my identity".

Whether team members bounced an idea off another member first or brought an issue directly to the team did not seem to correlate with their self-perception of power but did correlate with the team's perception of them as having power. The two team members most frequently mentioned as having power, i.e., nurse practitioner(1) and social worker(3) most frequently bounced issues off each other before bringing them to the team. This is consistent with the theory that "Power talks to Power".

Team members also mentioned that they felt it was alright to move in to fill power vacuums when there were changes on the team. This was viewed as healthy as long as the team was functioning well. In times of great upheaval or crisis situations where a great deal of change took place, it was not seen as healthy but more as inevitable as staff jockeyed for power positions. One team member likened it to a "pack of dogs sniffing each other".

In response to question 3, eight team members were named as having the least power in any given phase. Disciplines included in those named were Dietetics, Pharmacy, Medicine, Nursing, Social Work and Physical Therapy. All age ranges were represented. There were five females and five males. This statistic might be significant since the ratio in the total team members in all phases was two females:one male, and females always outnumbered the males in every team phase. Four of these named worked together in one team phase. None were the same as those identified in question 1 as having the most power. The team member most frequently named did deny a self-perception of power saying she has never wanted power. She saw other team members as also having little power. She felt listened to by the team when the issue involved her professional opinion. She also felt comfortable bringing any issue directly to the team.

In response to question 4, there was no team member questioned who felt he/she did not have some power within the team. All of the types or sources of power mentioned in the interviews are listed

in Appendix B. The most frequently mentioned source of power was professional expertise. Everyone felt they influenced team decision making re: diagnoses or treatment plans when they contributed their professional opinion. This is consistent with Wax's comment: "The keystone of power in a professional environment is competence." (p. 277).

In addition to sources of power which were identified by team members, other variables were identified by team members as somehow relating to the power issue. Examples of these variables are listed and detailed in Appendix C.

Only five team members mentioned a strong dual commitment of Geriatrics and interdisciplinary team care as being a source of power. Those who mentioned it tended to have been long-term team members. Some, perhaps recalled that this was the basic underlying tenet of the grant. It was this commitment that caused some team members to join the grant, e.g., the physical therapist who was warned by her university department not to take the position because of the chaos and the social worker who accepted the position after being warned that two previous social workers had been burned out by the Project.

Other than "expertise in individual profession", no one source of power stood out as a key to unlock the maze of power issues within the interdisciplinary team. However, to further delineate the power issues, it is interesting to consider some historical events occurring during the course of the Grant which involved several variables and several sources of power.

HISTORICAL EVENTS (See also Appendix A)

In PHASE 1, before the group was functioning as a team, the members looked toward the M.D. director as the leader, assuming that he had the power. Team members were meeting to begin developing a geriatric curriculum. Clinical training was lacking because no clinical base had been developed.

In PHASE 2, team members began showing individual professional expertise, broad knowledge of medical and health related issues, and knowledge of the elderly population. They began suggesting future directions for the Grant. The two team members with the largest percentage FTE were given authority by the director to gather information on developing a home care program. At this point the two team members had control of information. Other team members recognized the team's ability to organize (and for the first time the team began to develop some of its internal power). As team members worked on course issues, an interdisciplinary assessment tool, and organizing a new program, an interdependence began to emerge. Members who could channel energy into these specific issues began to have power within the team.

At the start of PHASE 2 the entity of "team" began to emerge. By the end of that phase the team was beginning to exercise control over some of its internal power; especially around the issue of prioritizing intervention of its few home care patients. Amount of work to be done, i.e., too few patients might have had a major negative impact on the team except that another crisis occurred. The funding for the Grant was eliminated. This was an externally mediated crisis which solidified the team. However, it also placed the team in a dependency state and when a "savior" rewrote the Grant, he met the dependency needs. The "savior" became the new director and, even though the percent FTE he devoted to the Grant was much less than the prior director, he wielded much more power within the team. He had charisma and an ability to organize but no commitment to geriatrics or interdisciplinary team care. While he was part of the team, he was not seen as an integral part of the clinical component of the team. At several points during PHASE 4 and 5 he was coopted by S.W.(3) to infuse energy into the sagging spirits of several key team members.

Another example of interactions between power sources and other variables occurred at the start of PHASE 6. A crisis was being anticipated by the team. Director(2) (who had come to be known as Big Daddy) was leaving. The skills of Director(3) were unknown other than that he had no strong commitment to Geriatrics. The Grant was more than half over and there were no overtures being made toward continuation funding. Three new M.D.'s (two fellows and one half-time staff member) were becoming part of the team (they were in the profession with ascribed power). One of the fellows had excellent verbal skills, wanted to be a geriatrician, professed a belief in team care, and wanted to remain in the city when the fellowship ended. This M.D. even spoke of some day heading the program. Since the team in a crisis was again looking for a "savior" this person had all the qualifications.

There was an initial struggle between the staff M.D. and the fellows. While the staff M.D. was part of the primary care team, the fellow's role in relation to the team had not yet been defined. The fellows had a desire for power. Without team input, they attempted to set up a geriatric consult service in the hospital; but that attracted minimal business. The team was confused about their role in relation to the fellows. Since a fellow is a student, the team thought their role was to teach. The fellows had an expectation of power. They thought their role was to teach geriatrics to the team. The fellow who professed the merits of interdisciplinary teams, in actuality, stated, "The M.D.'s should be the leaders and directors of patient care." Because there were too few patients for the influx of M.D.'s the R.N.'s lost some autonomy as R.N. practitioners in the clinic. The two R.N.'s divided their duties, one becoming coordinator of home care issues, the other coordinator of clinic issues. Because of the confusion surrounding the "savior" and education issues, and prior training of some staff to defer to physicians the team began to function in a more multidisciplinary manner. Control of information was used in several ways. One fellow refused to answer questions at patient staffings saying: "I went to medical school and am not about to turn the team into mini doctors." Prior to this, when significant issues arose, any team member felt comfortable calling for a

staff meeting. Now, no one did; so there were none. In addition, the social worker (Social Work is probably the profession most apt to question authority) was singled out by the fellows as a scapegoat. One of the fellows attempted to coopt an R.N. to use as a front for her power. The R.N. intentionally withdrew and attempted to be less visible by decreasing her team participation. The fellows made some good suggestions for program changes, explored opportunities for research and showed expertise in their individual professions. This added to the conflicting messages. The PT(2), whose professional expertise was recognized by everyone on the team, who had charisma and an ability to get along with everyone was the only non-threatening member of the team who had a strong dual commitment to geriatric and interdisciplinary team care. She decided, "I'm not going to let this team go down the tubes without a fight." She scheduled a meeting with the S.W.(3) (scapegoat). She noted that in the past, it was always the S.W.(3) who had the energy to say let's pick up the pieces and try again. Because of the scapegoat role the S.W.(3) no longer had the energy and her ability to gain trust was shaken. The P.T. became team coordinator during that time.

The Evaluator, aware that she was also being scapegoated, became intensely involved in trying to correct the team dysfunction. She had a very strong commitment to interdisciplinary teams. She held many private meetings with individual team members to discuss the problems and potential solutions. She suggested the services of a group of team facilitators. This was an example of an informal system picking up for formal system dysfunction.

The Team finally agreed and the M.D.(5) and S.W.(3) volunteered to work with the facilitator in scheduling two communication workshop sessions. The purpose of the workshops was to address the problems the team was encountering and to share feelings. Few of the team members' feelings were shared openly in these sessions but when asked to write them down for the group facilitators everyone complied. The central themes were fear of expressing opinions (especially to the M.D.'s), lack of trust, lack of understanding of interdisciplinary, and uncertainty regarding leadership.

The workshop facilitators diagnosed the problem as "the failure to talk to each other openly and personally". And indeed, there was not much open communication during the workshops. But a change occurred. After the sessions a great deal of time was devoted to discussing the meaning of interdisciplinary and to devising a definition which was acceptable to everyone.

The team began relating to the staff M.D. who was the most accessible (placement of desk). This M.D. also seemed more approachable. Most allied health team members began communicating more openly with each other.

Re-opening communication channels between team members seemed to help team members realize that they still held power for decision making.

Relating to a later power crisis, one team member stated it this way:

When certain team members aggressively attempted to coopt other team members to use as a power base from which to control the team, I saw three choices for the team.

1. to allow the new power structure
2. to tell the team member they wouldn't tolerate it
3. to ignore the power plays and go on with their business

The team thought about the second option but settled for the third; in essence disallowing the proposed power base and the power play failed.

In a well functioning interdisciplinary team, power is not necessarily ascribed by individual team members but is recognized and allowed by the majority of the team. If a team is truly interdisciplinary, it is the team itself (not the individuals within the team) which maintains control over the power. This author maintains that this team function of power broker is one of the more important maintenance functions of the team. Once this team became interdisciplinary, it managed to hold onto this function of power broker, even in its most trying phases. This author, therefore, hypothesizes that

1. Once a team reaches the point where the team itself is in control of the power, it will be able to suffer many insults and diminished effectiveness without causing the team to disintegrate.
2. To be interdisciplinary, all team members must have a self-perception of having power within the team.

The demise of a team can be very costly to both organization and patients. If an organization is willing to make a commitment to team development and maintenance within a complex area, it might be worth the effort to develop an interdisciplinary team.

CONCLUSION

This paper has explored some of the internal power variables existing within an interdisciplinary health care team. Perhaps it can serve as the basis for developing an instrument to assess the quality of interdisciplinary team function. It could also be used as a prototype in identifying problems and solutions for malfunctioning teams. Identification of power centers, strategies, and the currencies most frequently used in strategy tactics may aid in an understanding of both positive and negative implications of power within the interdisciplinary team.

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APPENDIX A

	<u>%FTE</u>	<u>Position</u>	<u>Stage of Development</u>	
Fall, 1975 - Spring, 1976	1.00 .33 .33 .33 .33 .33 1.00	Δ Dir.1 Δ O.T.1 Δ Ph.1 Δ S.W.1 Δ S.W.2 Δ Sp. Th.1 Δ Admin. Asst.1 Δ Secy.1	Forming?	Disorganized group, changeable, little cohesive team function. The process burned out 2 Pharmacists and 2 Social Workers. Interactions with organization and external environment consumed all of group's energy. Participants looked to director for leadership. Strong pressure to organize.
PHASE 1	1.00			
Fall, 1976	1.00 .20 .33 .50 .33 .33 .50 .33 .20 1.00	Dir.1 Δ M.D.1 O.T. Δ R.N.1 Δ Ph.2 Δ D1 Δ S.W.3 Sp. Th.1 Δ P.T.1 Admin. asst.1 Secy.1	Forming & *Norming	Interaction with organization and external environment still consuming energy but team begins to organize around the issue of course goals and student syllabus. Team begins to assume some authority to make decisions. Team gives O.T. authority to initiate process of getting course cross-listed. Pharmacist scapegoated. Norming was facilitated by the presence of concrete tasks requiring team member input.
PHASE 2	1.00			
Spring, 1977	1.00 .33 .75 .33 .33 .50 .33 1.00	Dir.1 O.T.1 R.N.1 Ph.2 D1 S.W.3 Sp. Th.1 Admin. Asst.1 Secy.1	Forming, Norming, *Storming	Director designated the R.N. as team leader. Director strongly encouraged R.N. and S.W. to gather data to begin a home care program. HCP began with small number of complex patients. Team began operating in multidisciplinary manner around patient issues. Grant finally hired a physician. Grant's re-funding denied. Director resigned. Hospital director asked Chief of Medicine to step in. V.A. Chief of Medicine wrote new grant and it was re-funded.
PHASE 3	1.00			

Δ Denotes change in team member or addition of team member.

*Most apparent stage.

(continued)

	<u>% FTE</u>	<u>Position</u>	<u>Stage of Development</u>	
Fall, 1977	.20	Δ Dir.2	Norming	New Director and structure of new grant designated M.D., R.N., S.W. as <u>Primary care team</u> for patient care. Director had expectation of power within the team. Began building patient population. Team began generating a great deal of energy.
	.50	Δ M.D.2+		
	1.00	R.N.1+		
	1.00	S.W.3+		
	1.00	Δ S.W.4		
	.50	O.T.1		
	.50	Δ P.T.2		
	.50	Ph.2		
	.50	D1		
	1.00	Admin. Asst.1		
PHASE 4	1.00	Secy.1		
Spring, 1978-	.20	Dir.2	Performing	Team was beginning to function in an interdisciplinary manner. Satisfaction with performance. Little attention to team process. Ceiling placed on patient numbers. Less energy generated. Some complacency regarding lack of patient turnover. Excitement generated around teaching enthusiastic group of students.
Spring, 1979	.50	M.D.2+		
	1.00	R.N.1+		
	1.00	S.W.3+		
	.50	Δ R.N.2		
	1.00	Δ S.W.5		
	.50	O.T.1		
	.50	Ph.2		
	.50	P.T.2		
	.50	Δ D2		
	.30	Δ Eval.1		
	1.00	Admin. Asst.1		
PHASE 5	1.00	Secy.1		

(continued)

+Primary Care Team

	<u>% FTE</u>	<u>Position</u>	<u>Stage of Development</u>	
Fall, 1979-	.05	Δ Dir.3	Performing	Initially performing well. Team very involved with a complex patient dying of cancer. Great learning experience for students. Excitement and tension surrounding increased patient numbers. Two geriatric M.D. fellows and a geriatric staff M.D. joined the team. Fellows uncertain of their role and denied the existence of the primary care team. Three M.D.'s began to conflict. Made a secret agreement not to disagree with one another in staffings. Team reverted to multidisciplinary functioning. Social Worker scapegoated. Evaluator scapegoated. Team survived.
Spring, 1980	.50	Δ M.D.3		
	1.00	R.N.1+	&	
	1.00	S.W.3+		
	.70	Δ M.D.4	*Storming	
	.70	Δ M.D.5		
	.50	R.N.2		
	.50	O.T.1		
	.50	P.T.2		
	.50	D.2		
	.50	Δ Ph.3		
	.30	Eval.1		
	1.00	Admin.		
		Asst.1		
PHASE 6	1.00	Secy.1		
Fall, 1980-	.05	Dir.3	Norming	One M.D. leaves for four months. Another M.D. leaves for private practice. New Psychiatrist functions as bridge between M.D.'s and allied health team members. New M.D. becomes scapegoat. Initially he was satisfied with this position. Team members jockey for position. Many new ideas and much enthusiasm generated. Research project begun. Psychiatrist moved desk from M.D. team members' offices to allied health team members' offices. Scheduled site visit by V.A. central office cancelled. Team begins realizing Grant will end in one year. Funding down for coming year. Admin. Asst. (first team member) attempts to salvage interdisciplinary team by eliminating several positions including her own. P.T. moves to another city. P.T. not replaced.
Spring, 1981	.70	M.D.4		
	.70	M.D.5	&	
	.40	Δ M.D.6		
	.70	Δ Psych.1	Performing	
	.80	R.N.1		
	1.00	S.W.3		
	.60	R.N.2		
	.50	O.T.1		
	.50	P.T.2		
	.50	D.2		
	.50	Δ Ph.4		
	1.00	Admin.		
		Asst.1		
PHASE 7	1.00	Secy.1		

(continued)

	<u>% FTE</u>	<u>Position</u>	<u>Stage of Development</u>	
Fall, 1981	.05	Dir.3	Disengaging	One M.D. continues as scapegoat. Begins to dislike the role. Leaves.
	.40	M.D.6		
	.70	Δ M.D.7	&	New M.D. enthusiastic, believes in geriatrics and interdisciplinary team care.
	.70	Psych.1		
	.80	R.N.1	*Performing	Many new consults. O.T. (second longest team member) disengages and then leaves. New O.T. hired.
	1.00	S.W.3		
	.60	R.N.2		
	.50	O.T.1		Team accomplishments recognized by V.A. Central Office. Some team members generate energy over new program proposal. Attempts made to coopt. V.A. staff for future program support.
	.50	D.2		
	.50	Ph.4		
	.50	Δ Admin. Asst.2		
PHASE 8	.50	Δ Secy.2		
Spring, 1982	.01	Dir.3	Performing,	New O.T. generates energy.
	.05	Δ Dir.4	*Disengaging,	New program proposal written.
	.70	M.D.7	Terminating	Team sees new "savior" in potential future director.
	.70	Psych.1		
	.80	R.N.1		Team is torn over disengagement issues.
	1.00	S.W.3		New Program approved. Great uncertainty regarding who will be future team members. Team members utilize many different coping strategies to deal with team termination.
	.60	R.N.2		
	.50	Δ O.T.2		
	.50	D.2		
	.50	Ph.4		
	.50	Admin. Asst.2		
PHASE 9	.50	Secy.2		

(continued)

	<u>% FTE</u>	<u>Position</u>	
Fall, 1982	.70	Dir.4	<u>Focus:</u> 1. Clinical 2. Teaching 3. Research
	.70	M.D.6	
	.70	M.D.7	
	.80	Psych.2	
	.40	R.N.1	
	.40	Δ R.N.3	
	.20	Ph.5	
	.20	D.?	
	.20	P.T.3	
	.50	O.T.?	
	1.00	S.W.?	
	.50	Secy.?	
	1.00	Coord.?	
PROJECTED	.20	Sp. Th.2	

APPENDIX B

No. of times the power source was cited by different interviewees	Sources of Power
1	Age
2	Sex
3	Personal attributes
5	Profession (discipline (ascribed vs. achieved power))
5	% FTE
5	Physical placement of desk
1	Knowledge of elderly population
1	Experience on teams
1	Verbal skills
1	Conceptual skills
3	Charisma
3	Energy (minimal personal problems)
1	Belief in the team
4	Ability to gain trust
6	Scapegoat
10	Expertise in individual profession (evidence of positive results)
1	Knowledge of the VA
4	Length of time on the "team" (historical knowledge)
2	Cooptation
6	Desire for power
4	Ability to see and fill a power vacuum
2	Control of information
3	Ability to identify holders of power
4	Broad knowledge of medical and health related issues
6	Ability to gain respect (personal and professional)
5	Strong dual commitment to geriatrics and interdisciplinary team care
1	Ability to get along with others
1	Knowledge of patient
3	Member of core team (primary care team)
2	Expectation of power
2	Ability to organize
3	Ability to identify the way team members use power

APPENDIX C

Other Power Variables

Prior training - e.g. old school "yes doctor" nurses vs. new school more autonomous nurses. Training re: acceptance or questioning of authority, e.g. social workers and doctors are trained to question authority. Conversely doctors are trained to act authoritarian, social workers are not.

Stereotypes - types of expectations team members bring to the team re: male-female relationships, deference for age, professional roles, etc.

Past associations with other professionals - whether on a social or professional basis, e.g., M.D. who has an occupational therapist for a sister or social worker for a friend might behave differently toward those professions than an M.D. whose only experience with an occupational therapist was re: activity programs or whose experience with a social worker was over placing a patient in a nursing home.

Amount of work to be done - Too many new patients at once might cause team members to become stressed and revert back to mono-disciplinary interventions and to decrease time for interdisciplinary communication. Too few new patients might cause team members to fight over priorities for intervention, decrease in communication, decrease in trusting behavior.

Disengagement - Depending on the number of team members leaving and their status on the team this may have effects ranging from decreased commitment, to opening of power vacuums, to anger or distrust between team members.

Type of patients - Dictate types of professionals who must get involved.

Crisis situations - Major changes produce potential for increased anxiety, dependency and suggestibility. It is during a crisis that search for a "savior" might occur. Crisis situations may also be viewed as offering potential for positive change. If the crisis is external, it can help solidify the team.