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AN EXPLORATORY STUDY OF THE FUNCTIONS OF HEALTH TEAM ROUNDS  
ON THE MEDICAL AND PEDIATRIC SERVICES  
OF AN ACADEMIC HEALTH CENTER

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Introduction

Studying health care teams in an experimentally controlled long-term care setting is of little help in studying health care teams naturally in an acute care hospital. That is our overall conclusion from our preliminary efforts to make such a transition in our research on health care teams. We've found ourselves repeatedly returning to basic questions that we thought had been answered. These questions include: What is the purpose of a health care team? How does it function? What are its outcomes? The truth of what was expressed at the panel session at the Third Annual Conference on Interdisciplinary Health Care Teams--that studying health care teams is like "shooting at a moving target" (Baldwin, Thomas and Schmitt, 1981)--has been made evident to us. The answers to such questions change as the teams and the setting that are the focus of study change.

In this paper we will present first the theory, methods and key findings from an initial study of health care teams, which was designed as a quasi-experiment in a long-term care institution. Next, we will describe our present study, which, in its first stages, has been an exploratory descriptive study of health care teams in a field setting, a tertiary care academic health center, which is quite different from the long-term care setting studied initially. In the first study, the theory tested was explicit and variables were controlled and operationalized to permit a test of that theory. Our problems with the present study have emerged from the struggle to articulate theoretical concepts and hypotheses relevant to the types of health care teams that have been the focus of our descriptive efforts in the acute care hospital. An additional problem has been the difficulty of operationally defining and measuring the concepts and hypotheses felt to hold theoretical and practical importance. We will discuss the methods we have used in the present study, our descriptive findings and our working conceptual model.

The Initial Study

The first study of health care teams with which two of the present authors were involved (Schmitt as a co-investigator and Farrell as an analyst consultant) was a quasi-experimental study of four health care teams in a long-term care institution (Feiger and Schmitt, 1979; Schmitt, Watson, Feiger and Williams, 1981). Conceptually, this first

study attempted to test some of the ideology about health care teams existing in the literature through linking that literature with theory and empirical research in small groups. Specifically, we were interested in testing the hypothesis that collegial relations among team members were related positively to achievement of a variety of patient care outcomes. By "collegial" we meant an interaction pattern that reflected relatively equal participation in patient discussions. The patient care outcomes identified as relevant and important for a group of chronically ill, institutionalized diabetic patients were multi-dimensional.

The teams deliberately were created with an interdisciplinary membership reflecting the professional resources needed to accomplish the patient goals identified as important. Different members of the team had expertise in different outcome areas. Clinical nurse specialists, a dietitian, and an endocrinologist-gerontologist made up the teams. They were well equipped to deal with the patients' medical problem of diabetes as well as the multiple other medical, physical, psychological and social needs that the patient had. Progress depended on the ability of the teams to solve problems in these different, but related, outcome areas. Each team established individualized patient goals using a commonly identified set of overall goals derived for this particular group of patients. These goals were written and formed the basis of health care plans. Each of the four teams was responsible for delivering care to its group of patients, and arranged regular feedback sessions to monitor patients' progress towards the goals (see Schmitt, Watson, Feiger and Williams, 1981 for details). A key point in this initial study is that we and the team members were familiar with the composition, structure, and goals of the teams. We knew that properties were similar among the four teams.

Patients had been assigned to the four teams via a stratified, random assignment process. Our major research question focused on the relationship between interaction process in the teams and the ability of the teams to achieve their desired outcomes. The quasi-experimental design achieved control over many variables that would otherwise have made it extremely difficult to infer that differences in outcomes were indeed the result of the interaction processes.

All team meetings were videotaped so team interaction could be studied in considerable detail. We chose to focus on measuring degree of collegiality in the interaction process because the relevant literature from small group research--almost all of it conducted in the laboratory--suggests that groups that decentralize their communication and decision making processes are more successful at problem solving tasks (see the review of this literature in Feiger and Schmitt, 1979). Deriving hypotheses from empirical research on the effects of status differences in small groups and from literature on relationships between health care professionals, we predicted that a key problem for these teams would be overcoming the "natural" tendency to make the physician central to the communication and decision making, regardless of whether this was appropriate to the patient's problem. This could limit utilization of the other team members' expertise.

We developed interaction measures of the extent to which the teams were able to create collegial interaction patterns, and related these

patterns to the outcome measures developed to look at patient progress. We found modest support in a perfect rank order correlation of the four teams for the predicted positive relationship between collegiality and patient care outcomes. These findings then led us to study the same question in the acute care setting: What is the relationship between collegiality and patient outcomes? However, as our field observations have progressed, we have learned that the purpose, functioning and outcomes of these teams seem quite different from the long-term care facility teams studied previously.

### The Current Study of Health Care Teams in the Acute Care Setting

#### Initial Stage: Two Kinds of Teams

We began our current study of health care teams in the acute care setting by observing a visible aspect of "team" activity called Health Team Rounds in several units of the Medicine Service of the hospital. Health Team Rounds (hereafter referred to as H.T.R.) are one hour, once weekly meetings held on each Medical unit. Historically, meetings of this type and by this name have been ongoing in the Medical Service for at least fifteen years. This was documented by a memo retrieved from a staff member's files dated June, 1968 in which goals and procedures for the ongoing H.T.R.'s were restated by an Assistant Professor of Medicine. Another interviewee and retired long-term employee has suggested to us that such meetings actually have been ongoing for a lot longer than fifteen years. She recalled that weekly "Social Service Rounds" attracting a variety of disciplines similar to those presently attending H.T.R.'s had been held on the Medical Service since the 1950's, if not earlier.

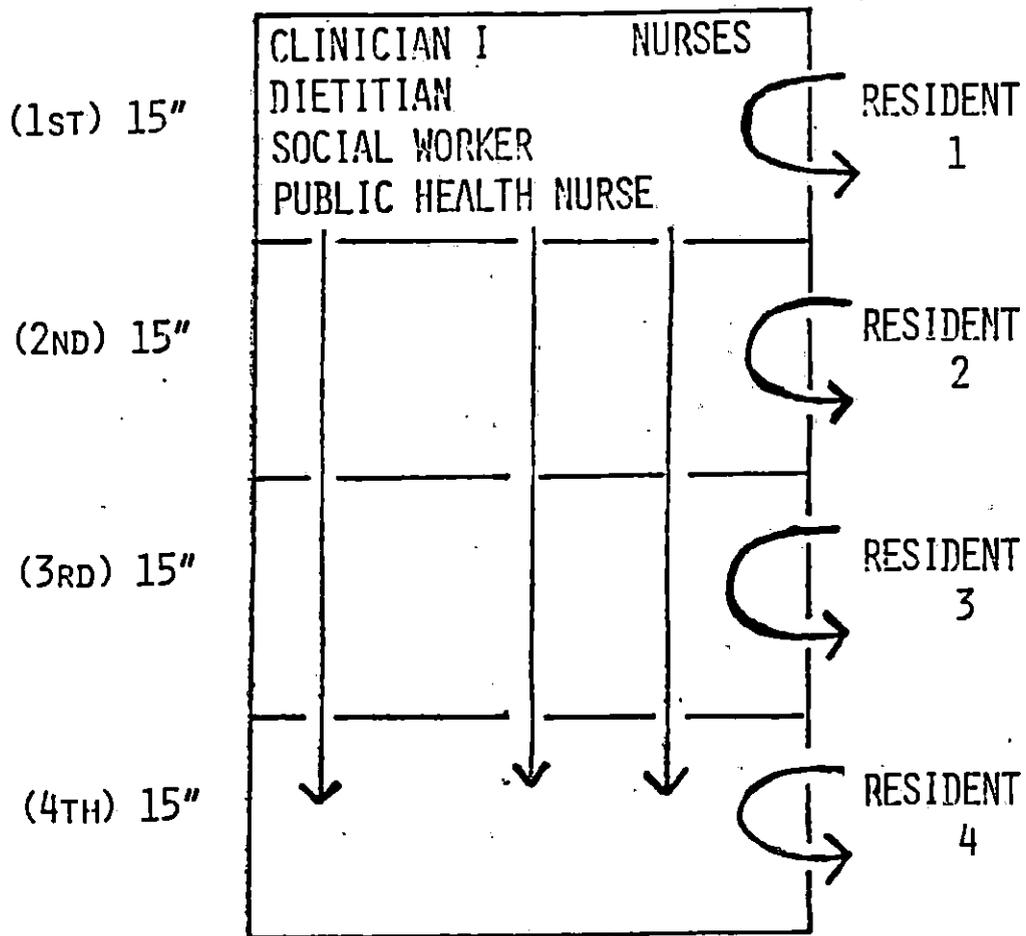
The Rounds were attended by four first year residents, staff nurses, a social worker, a dietitian, a community health nurse and, frequently, students from diverse professions including chaplaincy training. The four first year residents, who are assigned for a period of several weeks to the particular unit where rounds are being held, rotate in succession for about fifteen minutes each through the hourly meetings. For each first year resident, the Clinician I (head nurse) will call out a list of patients assigned to the first year resident for medical care. As each patient is named, discussion, varying in length and focus, occurs about that patient. By the end of the hour all patients on the unit have been reviewed in this systematic fashion. The staff nurses, who are responsible for continuing care on the floor, move in and out of the meeting in relation to patient care responsibilities at that time. The rest of the group remains present for the entire meeting (see Illustration 1).

Our initial sense that there were some fundamental differences in these acute care "teams" arose from our attempt to define measurable outcomes attributable to H.T.R.'s. The variation in patient diagnoses and related problems defied the construction of any discrete set of outcome measures. More importantly, we realized that the one hour, once a week H.T.R. was only a small part of the collective effort to treat any given patient. On the average, each patient would receive only two to two and a half minutes of attention. Patient changes

ILLUSTRATION 1

HEALTH TEAM

ROUNDS ON THE MEDICAL SERVICE



based on a comprehensive set of outcome measures, such as those we had used in the chronic illness setting, certainly could not be attributed to activity in the H.T.R.'s.

Such outcomes are instead the responsibility of the interdisciplinary group of health professionals who form the Individual Patient Team (hereafter referred to as the I.P.T.), whose interrelated effort is uniquely organized around each patient on the unit. An example of such an I.P.T. is shown in Illustration 2. The core of this team is the first year resident and the primary nurse, but it almost always includes a variety of others, some of whom may never be present at H.T.R.'s. For example, on the Medicine Service, physicians involved in the patient's care, except the first year resident, are not present at H.T.R.'s. The primary nurse's presence at H.T.R.'s depends on her shift assignment. Conversely, many of the individuals involved in H.T.R.'s might have little direct care involvement with a given patient being discussed.

The realization that the structure of H.T.R.'s in the acute care setting was very different (i.e., those present were not the care givers per se), led us in two separate directions. First, we were anxious to focus attention on the structures, group processes and outcomes of the I.P.T.'s assembled for each patient. Illustration 3 shows our first attempt to look at the variations in relationships among those team members and from patient to patient by asking the nurses involved to complete the Bales Interpersonal Rating Scales (Bales, 1970; 1980). Two observations can be made about the illustrations depicting teams organized around these two different patients. First, the team membership varied considerably from one patient to the next; and, second, there is quite a difference in the pattern of relationships among the team members in the two teams. We expect to expand our study of these types of variables in the I.P.T.'s and what accounts for variation.\* Second, we wished to examine what were the structures, processes and outcomes of the H.T.R.'s. This is the focus of the remainder of this paper. To date, we have pursued this examination of H.T.R.'s through exploratory interviews with the variety of health professionals who attend these meetings on several different units of the Medical Service. In addition, we have made comparative observations and conducted exploratory interviews with participants in similar H.T.R.'s on the Pediatric Service.

#### Exploratory Interviews about H.T.R.'s in the Medical Service

A semi-structured interview guide provided the focus for ten exploratory interviews on the Medical Service. Those interviewed included first year residents, a second year resident, nurses, a social worker,

\*One serendipitous observation is that, in these cases, there is a relationship between the nurse's dominance and the patient's socio-economic status. In Group 1, where the patient is a black migrant worker, the nurse dominates; while in Group 2 where the patient is a middle class wife of a businessman, the M.D.'s dominate.

ILLUSTRATION 2

INDIVIDUAL PATIENT

TEAM  
(EXAMPLE)

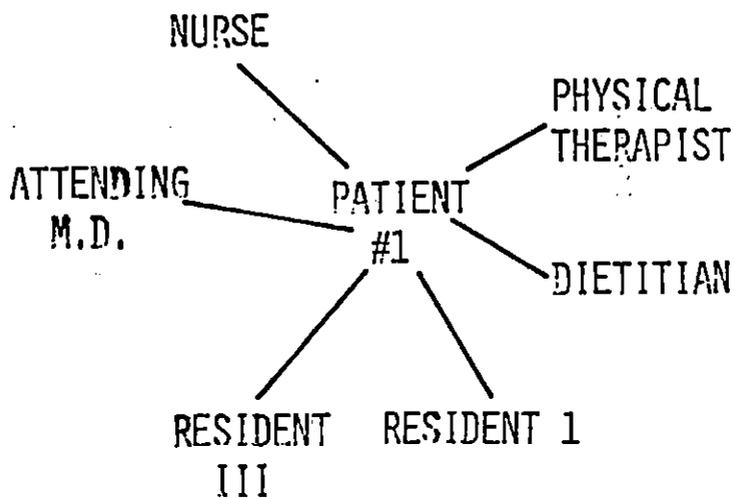
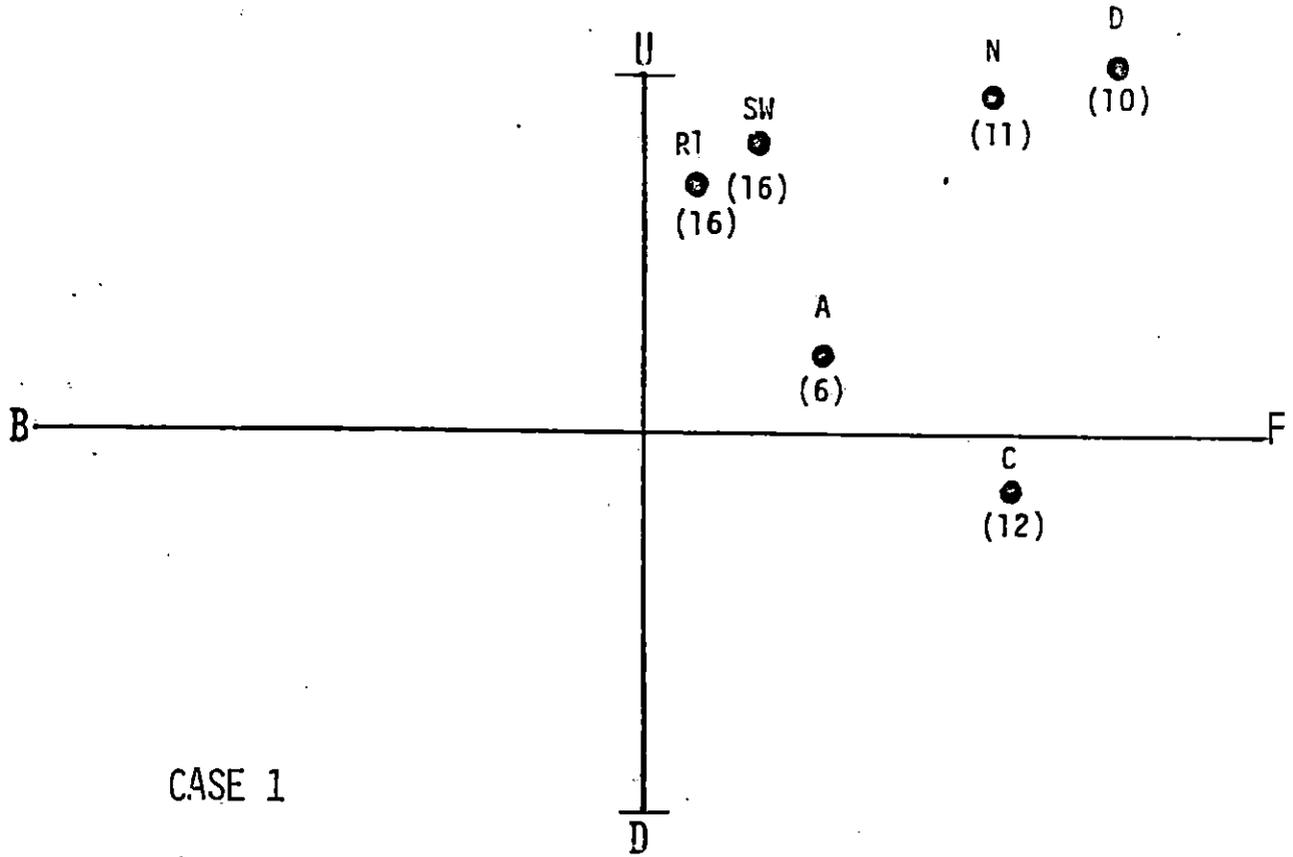
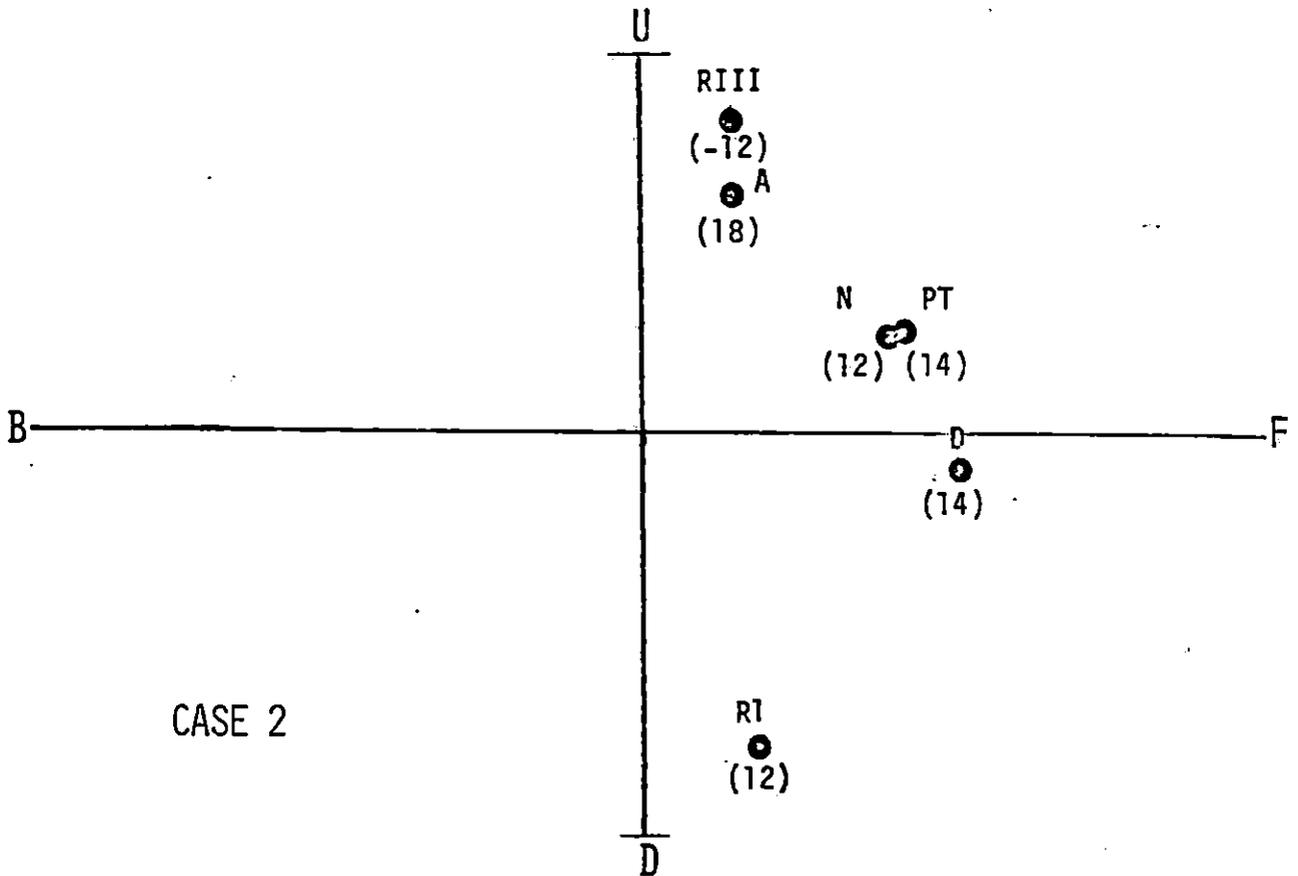


ILLUSTRATION 3  
DESCRIPTION OF TWO P.T.'S USING BALES  
THREE DIMENSIONAL INTERPERSONAL RATING SCALES



CASE 1



CASE 2

and a dietitian from the units where observations were made. The questions covered a range of topics of interest to us as the result of the observations. These questions are listed in Illustration 4. Since we were puzzled about the role of H.T.R.'s in relation to patient care, a key set of questions had to do with participants' orientation to and perceptions of the purposes of H.T.R.'s. Other questions had to do with variations in structure that had been observed, and our curiosity about the relationship between these structural variations and the meeting's purposes. A third set of questions focused on residents' reactions to H.T.R.'s since, in observing H.T.R.'s, there seemed to be various efforts to insure their participation.

#### Preliminary Findings About H.T.R.'s in the Medical Service

Interview data suggest that the purposes of H.T.R.'s on the Medical Service are not clear to the participants. None reported receiving a formal orientation to H.T.R.'s. The staff nurses learned about H.T.R.'s by being present in them. The Clinician I's (head nurses) had learned to conduct them by example of the Clinician I on whose unit they had been a staff nurse. As one Clinician I said:

I hope you can do something with H.T.R.'s. Show me how to be an effective leader--what works and what doesn't. My own development has been by trial and error.

The social worker reported having another social worker role model for her in H.T.R.'s the first week on the job: Housestaff had no role models and had learned by participation in them after their assignment to their first unit. This could be a painful learning process as illustrated by the not atypical comments of one resident:

I never got any orientation to H.T.R.'s. I started on Unit (X) and one day the nurse clinician said to me, "You're supposed to be in H.T.R. now." I didn't know what they were. I went into this room and sat down. The nurse called out a patient's name, and then there was silence. And, everybody looked at me. I didn't know what I was supposed to do. If they'd asked me questions or something it would have been easier. Gradually, I learned what I was supposed to say. Now, I have a regular set of comments I go through. I always try to direct a comment at each member of the group.

A Clinician I recalled that a written orientation to H.T.R.'s was provided to the first year residents in two paragraphs on the last page of a five page "Orientation for Housestaff" sheet that had been prepared and given to all first year residents by the Medical Nursing Service, but no resident interviewed mentioned the written information.

Given the lack of formal orientation, it is not surprising that interviewees' comments about the purposes of H.T.R.'s varied. Their comments, our earlier observations, and our knowledge of small group theory led us to develop an initial categorization of the variable purposes of these meetings. These categories include: instrumental integration

ILLUSTRATION 4  
HOSPITAL TEAM STUDY INTERVIEW GUIDE

- Q1 What are the various meetings held to share information between professions on the floor? E.g., rounds, regularly scheduled meetings, or conferences.
- Q2 Where are health team rounds held?
- Q3 Who attends health team rounds?
- Q4 Do you know how health team rounds got started?
- Q5 What do you think the purpose(s) of health team rounds is (are)?
- Q6 Do you think things would be different without health team rounds?
- Q7 How does the housestaff feel about participation in HTR?
- 7.a Are they cooperative?
- 7.b Do you think they feel they get something out of them?
- 7.c Is how they act in health team rounds different or the same as they act on the floor?
- 7.d If there are differences in how various housestaff react to HTR, what do you think accounts for the difference?
- 7.e Do you know what kind of orientation they get to HTR?
- 7.f Do they see people who attend HTR at any other time during the week?
- 7.g What sort of impact (interdisciplinary) do you think HTR has on housestaff, if any?
- Q8 If you compared a health team rounds occurring in July, with one in February, and one in June, are they pretty much the same or different depending on the time of year?
- Q9 Who is in charge of HTR?
- Q10 (For Clinician I's) How did you learn to conduct health team rounds?
- Q11 What is the format (structure) of HTR's? Why is it organized this way?
- Q12 What is your specific role in HTR?
- Q13 Do you serve refreshments at HTR? Why or why not? Who is responsible for bringing refreshments? Who pays for it?
- Q14 How well do you think the various members of HTR know each other?
- |             |                |
|-------------|----------------|
| Nurses - SW | Dietitian - SW |
| SW - Doc    | PHN - Doc Etc. |
- Q15 Are there any relationships that are tense or regular sources of conflict? If yes, why do you think that is?

and feedback, socio-emotional needs and group solidarity, education, and political processes.

#### Instrumental Integration and Feedback

The most explicit reason stated for holding H.T.R.'s was for inter-disciplinary exchange of information, coordination of patient care and discharge planning. All those interviewed mentioned this purpose, using expressions such as "looking at everything together", "creating a unified approach" and "discharge planning". The dietitian saw H.T.R.'s, as presently constituted, serving no purpose that called on her resources. She said that the purpose was supposed to be interdisciplinary communication, but felt left out of this communication. She said they did focus on "disposition of patients, a concern of the social worker on the team".

When asked whether things would be different without H.T.R.'s it was the efficiency of coordination and the efficiency of communication that was identified by most respondents as the key element of care that would be lost. Several people pointed out that pieces of information would have to be conveyed to each team member separately. In the words of one resident "the residents would get pretty tired of that." Most respondents also felt, however, that without H.T.R.'s such activities as discharge planning would still be accomplished, for two specific reasons. First, team members such as the social worker and community health nurse had specifically assigned responsibilities in this area. Second, there was a good network of informal communication facilitated by the following: assignment of residents to units (instead of having a patient load scattered around the Medical Service); the availability of personnel, such as the social worker, on every unit; the system of primary nursing; and, the geographical arrangement of the 24 bed unit which, according to one of the residents, meant "you bump into a nurse every ten minutes". Typical of the responses to what would be lost without H.T.R.'s are those of a resident, nurse and social worker respectively:

Resident: Well, I'm not sure. I guess things would still get done and the patient would go home, but I'm not sure it would be as good a job and it would take a lot longer. It would be harder to coordinate. It (H.T.R.'s) only takes twenty minutes a week; and, I think a lot gets done in that time. I find myself some weeks looking forward to H.T.R.'s. I have problems and I'm eager to discuss them.

Nurse: I'm ashamed to say it, but it would probably be pretty much the same because people like our social worker and dietitian don't wait for H.T.R.'s to initiate things. They're really on top of the situation. And, also, because of the good informal communication often people pretty much know what's going on.

Maybe for the housestaff who are not so good at communicating informally. It's the one time you can get them to talk to you. Then I learn things I didn't know they were doing.

Social Worker: Well, personally it wouldn't affect me (if there were no H.T.R.'s). I'd still communicate with others and patients would still get my service. But other things would be missed—the more total communication and the systematic review. There definitely would be a loss.

### Socio-emotional Needs and Group Solidarity

Our first sense was that one of the purposes of H.T.R.'s might be the reduction of tension generated in the care process and the enhancement of group solidarity. We observed the varying importance of refreshments served as part of H.T.R.'s. In the interviews all the residents acknowledged that the availability of refreshments was one of the things that drew them to the meetings:

I don't remember too much difference between H.T.R.'s on different floors. Some of them had real good food, though. That always made it easier to come to H.T.R.'s, if I knew there was going to be something good to eat.

Some H.T.R.'s are small, very business-like and matter-of-fact. On other floors, everybody comes. It's more of a social occasion, with coffee and doughnuts. There's more informal talk . . . It's a relief from all the other matter-of-fact work I have to do. I prefer the more socially oriented H.T.R.'s.

On the other hand, Clinician I attitudes varied all the way from explicitly rejecting refreshments ("H.T.R.'s is not a social event and no refreshments are provided") to a laissez faire attitude ("Sometimes we have them; sometimes we don't") to active weekly planning for refreshments ("Refreshments lend informality, bring people together and are a way of sharing. We bring food as much for us as the housestaff").

Other aspects of H.T.R.'s mentioned in the interviews suggest additional ways H.T.R.'s serve to reduce tension and maintain solidarity. Two first year residents and the social worker mentioned H.T.R.'s as a place to "vent your feelings and get disagreements between health care providers worked out." One first year resident expressed the desire for this type of activity to be more a part of H.T.R.'s in Medicine than it is at present.

### Education

Several respondents mentioned the educational aspects of H.T.R.'s.

The social worker mentioned specific things she had learned from the dietitian on her units in H.T.R.'s. A nurse and a resident expressed the desire to have a pharmacist be present to learn from. Some residents were thought to be good at educating other team members. On the other hand, one Clinician I's behavior suggested that it is the first year resident who is being educated. She sometimes quizzed residents new to the floor in H.T.R.'s:

Sometimes I ask questions just to see what kind of doctor they are; how good they are when they're an unknown quantity. Like the new resident who just came on service. He has some of the sickest patients. I wanted to find out how much he knew; whether he's read the charts.

There were wide differences of opinion about the impact of H.T.R.'s on residents. While many of the non-physician respondents interviewed felt that the residents learned little or nothing from H.T.R.'s, two of the three physicians were articulate about the impact H.T.R.'s had had on their perceptions of patients and history taking practices. The third recognized the opportunity to learn, but had passed it up:

I'm more sensitive to asking, "How's Mr. so-and-so walking?" I mean, that's really important, and I'm not unfamiliar with ADL's. I've worked in a nursing home. It's just that H.T.R.'s are a reminder.

The H.T.R.'s and the kind of questions that routinely come up there about family, home environment, how the patient will get along and what the patient will need after discharge have influenced my history taking. Before, when I did a social history, I'd just get years of education, occupation, and so forth. Now I know it matters who they live with, where and so forth, and I ask those questions as I go along. Then I'm ready with the answers in H.T.R.'s. I have a more total view of needs and goals--we want to get the patient healthy and able to function at home again. I used to just worry about getting the medical problem under control.

I never had any formal orientation to discharge planning nor to what words like SNF and ACCESS mean. I was too busy to worry about not knowing; the social worker took care of it. Maybe when I get out in practice and have to do it myself, I'll regret not having the information.

### Political Processes

The potential political aspects of these H.T.R.'s were not easy to determine from the interview data. Other writers (Brown, 1982; Temkin-Greener, 1982; and Furnham, Pendleton and Manicom, 1981) suggest that this has been an important dimension of health care team experience. The key axis of such political activity would be the inter-professional axis: nurse vs. doctor, social worker vs. nurse, and

so forth. A strong identification with the ideology of a particular profession contributes to developing stereotyped responses to the other professions, especially if the responsibilities of the professions overlap. Causes of behavior are attributed differently depending on whether the person involved is of one's own or another profession. Furnham, Pendleton and Manicom suggest that:

"professional prejudices are most likely to be . . . manifest in institutionalized meetings or groups such as the health care team and the case conference. Unless the conditions under which these groups are constituted and maintained are clearly set out they are likely to be a forum of professional prejudice and jealousy rather than team medicine".  
(1981:297)

Elements of this interprofessional tug-of-war could be inferred from the history of H.T.R.'s in the Medical Service and observed in the present activities of H.T.R.'s. Historically, in "Social Service Rounds", the precursor of the present H.T.R.'s, leadership was vested in the social worker. By 1968, a memo (referred to earlier) spelled out the leadership, purposes, and procedure of H.T.R.'s and specified that the first year resident would carry the responsibility for the organization and conduct of rounds, including the identification of the patients to be discussed. At the present time in the Medicine Service, all interviewed agreed that the Clinician I (head nurse) organized and moderated H.T.R.'s. All three Clinician I's interviewed mentioned that one way they achieved control over the residents in H.T.R.'s was by retaining the practice of calling the patients' names.

"Sometimes the doctor takes over calling the names. He thinks he's in charge. I don't like that because they try to rush through a patient who needs to be discussed."

Nursing strength in H.T.R.'s has increased between the late 1960's and the present with the addition of a community health nurse. This nurse's function is sometimes perceived by social work as overlapping with social work responsibilities in the area of discharge planning. In the larger organizational setting, this period of 10-15 years has seen changes that may have affected the relationship among professionals. Nursing education and practice in this institution moved out from under the Medical School umbrella to autonomous status; and dramatic changes in educational preparation of both staff and nursing leadership have occurred, thereby increasing nursing's relative power and status. One first year resident described his experience of this nursing power in relation to H.T.R.'s. He complained that H.T.R.'s interrupted his daily work rounds and said that first year residents ought to be polled to see what time they would prefer for H.T.R.'s.

"The resident is at the bottom in the health care team. They pick up the slack when activities fall outside everybody else's job descriptions, or when the team doesn't work well. They do everything that has to be done that no one else wants to do. They work three times as long

as anyone else. When I complain, the nurses tell me I chose to be a doctor. I resent being summoned to H.T.R.'s. I think the nurses are presumptive about my availability."

Nurses experienced the residents' resistance to attending H.T.R.'s as a problem. As noted earlier, refreshments are sometimes used to attract them to H.T.R.'s. Calling residents into the H.T.R.'s represents one of the more challenging interprofessional tasks for nurses:

"I used to hate being in charge of Unit (X), as a staff nurse, on the day of H.T.R.'s. The doctors give you such a hard time, especially if you're a staff nurse. Everybody wants to go last."

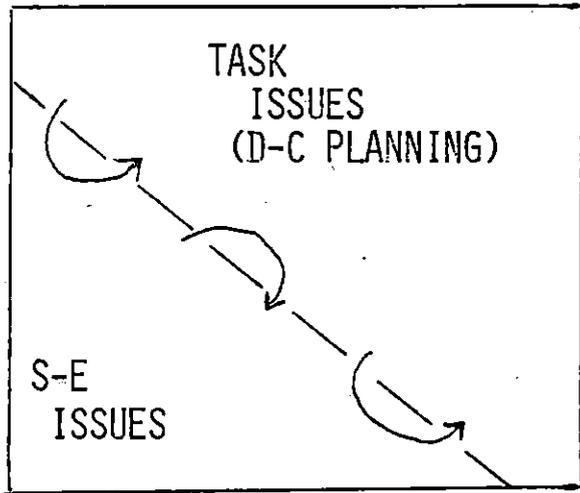
Despite this undercurrent of political tension, there was an overall sense pervading the interviews with the residents that H.T.R.'s were a useful interprofessional exchange; positive interprofessional feelings were strong. There was the perception that "all the disciplines are strong"; "the nurses are sharper"; "the doctor and primary nurse are the care team, the ones responsible for the total patient. Other disciplines like the social worker and the dietitian are helpful, but in limited areas." Some nurses' reactions towards physician members seemed more negative and stereotypical. The social worker felt "people work real well together here; they respect each other as colleagues. I feel respected." Only the dietitian was completely negative about the team experience.

#### Observations and Exploratory Interviews on the Pediatric Service

In an attempt to corroborate and amplify our observations on the Medical Service we carried out comparable observations and exploratory interviews on the Pediatric Service. Formal observations were made of H.T.R.'s on the three general pediatric units. Six formal interviews were held with a resident, two Clinician I's, a social worker, a retired Clinician I and the dietitian who serves all three units. In addition, participant observation and several informal interviews were conducted over the course of three months on the three units. These informal interviews included a community health nurse, two additional social workers, a staff nurse and a Clinician II (clinical nurse specialist).

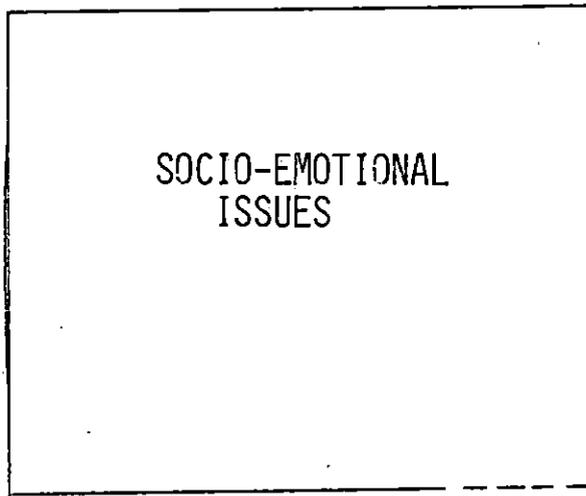
The H.T.R.'s held on three units in the Pediatric Service consist of two distinct types (see Illustration 5). Formal H.T.R.'s are attended by residents, faculty physicians, Clinician I, staff nurses, dietitian and social worker on all three units. In addition, the chaplain, child life specialists, Clinician II, community health nurse, and students also attend on a regular basis on two of the units. These H.T.R.'s have a psychosocial - educational emphasis. While they are available to the entire staff, they are directed specifically to the physicians-in-training, who may begin the H.T.R.'s with a brief description of a particular patient. Leadership varies from unit to unit. Psychiatrists, who are consultants to patient care on the unit, lead the discussion on two units. They use a group interactive approach to ferret out problems, assist members in problem-solving and educate

ILLUSTRATION 5  
DIFFERENCES IN H.T.R. ON  
MEDICINE AND PEDIATRICS



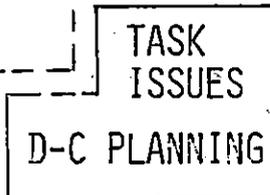
MEDICAL  
UNITS

H.T.R.



PEDIATRIC  
UNITS

H.T.R.



KARDEX ROUNDS

them by helping them to link their previous knowledge and experience to the present situation. On the third unit the Clinician I moderates and a pediatrician conducts psychosocially oriented discussion about selected patients.

Team members interviewed felt that the purpose of H.T.R.'s was to deal with psychosocial issues. One Clinician I stated that the purpose was to help staff deal with difficult issues in identified patient situations. A resident stated that, for him, the chief purpose was "to really let go and work out feelings." These feelings could relate directly to patient problems or to staff problems. He gave an example of the best H.T.R.'s he had attended. They dealt with the difficulty the entire staff was experiencing in caring for a child with a poor prognosis and whose family was very warm and involved in her care. Each group member present at H.T.R.'s expressed their grief and frustration verbally as well as by crying. In his view, this kind of experiential and emotional sharing was the most vital function of H.T.R.'s.

Both the social worker and a nurse noted that one definite purpose of H.T.R.'s was to raise the staff's awareness of the importance of psychosocial issues. Each had participated in H.T.R.'s for over a decade and noted that "this discussion of psychological issues has a place in weekly rounds in the Pediatric Service."

When the members were asked if things would be different without H.T.R.'s, each one stated that necessary patient information would be lost, and the resulting patient care would be greatly compromised. A physician offered the opinion that the most beneficial H.T.R.'s are balanced between dealing with psychosocial issues and attending to the "nuts and bolts" of discharge planning.

While H.T.R.'s in Pediatrics emphasize an educational approach to psychosocial issues and group solidarity, a second meeting exists on each of the three units to deal with discharge planning. In these weekly "Kardex" rounds, the Clinician I, social worker, child life specialist, community health nurse and a chaplain review all patients. One unit includes staff (primary) nurses when they are able to attend and participate. Physicians do not attend these meetings. Except for this difference in membership, Kardex Rounds are comparable in structure and purpose to H.T.R.'s on Medicine.

#### Comparison Between the Two Services

The four purposes for H.T.R.'s (cited previously for Medicine) are present but have different emphasis in Pediatrics. Instrumental integration around discharge planning is accomplished in the interdisciplinary Kardex review meeting without physicians present; whereas in Medicine the resident is present, albeit reluctantly, in H.T.R.'s which focus primarily on discharge planning. The physician's role in discharge planning, therefore, seems unclear. The resident's presence in H.T.R.'s in medicine may be dictated by a desire to expose physicians to this area of health care, but it is not one where the physician-in-training experiences support for this knowledge acquisition. No other physicians are present at these H.T.R.'s in Medicine.

Attention to socioemotional needs and group solidarity issues are both dealt with directly in Pediatrics by discussion of the human reactions experienced by team members in caring for very ill, and often, dying children and their families. The socialization of physician-in-training and others about these aspects of patient care is treated seriously and reinforced by the fact that faculty physicians play a dominant role in the educational aspects of these H.T.R.'s.

The political dimension of H.T.R.'s in pediatrics may be reflected in the expectation that all disciplines participate in H.T.R.'s because the Pediatric Service is committed to interdisciplinary care. On the other hand, the observed participation of all disciplines except Medicine at these meetings is low.

Despite the variations in structure and emphasis present between Medicine and Pediatrics, our initial impressions about the important variables and the overall purposes or functions of H.T.R.'s have been reinforced by our comparison of the two services.

### Our Working Model

In the study in the long-term care setting, the focus of the design, theory and hypothesis testing was on collegiality and its relationship to a set of comprehensive patient care outcomes. Most of the other categories of variables were controlled by the study design. Our explanation of the differences emerging in the interaction processes led back to the biographical characteristics of the physicians, since these were the only changing members of the teams. In the present study, none of the categories of variables are controlled by virtue of an experimental design. The effort has been an exploratory, descriptive one, i.e., to identify variables that are of theoretical interest and of practical importance in the acute care setting. Our efforts have led us to realign our thinking, focusing on the determinants of variations in H.T.R.'s as well as the impact of this variation on outcome for staff and patients.

The initial stage of theory-building about a phenomenon involves the construction of a paradigm - a set of assumptions about the properties of the phenomenon that are important to include in a theory, along with some assumptions about how these properties are inter-related. As a result of our exploratory study we have isolated several variable properties of H.T.R.'s that seem to have the potential of being important both theoretically and practically. It would take another paper to present our thinking about how these properties are interrelated, so at this point we will simply present a sketch of the direction our thinking is moving. The properties of H.T.R.'s that we have isolated as theoretically and practically of interest are - 1) degree of emphasis on socio-emotional needs, 2) degree of emphasis on education of members, 3) degree of emphasis on integration of disciplines, 4) degree of dominance of one discipline over another, and 5) degree of "anomie" or uncertainty about one's own role and the purpose of H.T.R.'s in team members.

We have observed variation in these properties both within and across

services. Some of the variation may be due to the idiosyncratic history of the groups or to the unique personalities of central members. But we are currently assuming that the variations are not random, and we are drawing on theories of groups to derive hypotheses about what might be causing the variation. For example, Burke (1967) has suggested that the degree of emphasis on socio-emotional processes is dependent upon the degree of strain the members experience in working together or accomplishing their goals. The care of certain types of patients generates more strain than others. For example, caring for very ill children, some of whom are dying, generates more strain than caring for adult patients with "expected", routine illnesses. Thus, we would expect H.T.R.'s on the Pediatric Service to spend more time attending to the emotional needs of team members. This hypothesis is only one example of our thinking about the factors affecting the properties of the teams.

We are also developing hypotheses about how variations in the properties of the teams are related to outcome variables. The outcome variables we are currently examining are 1) effectiveness of discharge planning, 2) effectiveness of H.T.R.'s as agents of education, and 3) degree of member satisfaction and commitment to the team. Following through on our use of Burke's theory, it might be argued that, in services like Pediatrics, when the emotional needs of team members are higher and there is less emphasis on socio-emotional needs in H.T.R.'s a) the less committed members will be to the unit, b) the higher the turnover will be of staff, and c) the less effective the discharge planning will be. Again, this is only an example of the direction of our thinking.

Having completed the exploratory stage of this study, our next step is to continue refining our conceptualization of the variables and deriving hypotheses from small group theory. We have already begun to develop measures of some of our key variables, making use of existing scales with known validity and reliability wherever possible. After our working model is complete, we will test it on a larger sample of teams drawn from a variety of services.

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