

**INTERDISCIPLINARY HEALTH TEAM CARE:
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A Conceptual Model for Interdisciplinary Healthcare Team Development and Survival

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I. BACKGROUND

There are many theories, models, and schools of thought which have influenced the way professionals view interdisciplinary healthcare team (IDHT) development and function. The fields of Group Dynamics (Royer, 1976) and Organizational Development (Perrow, 1976) are, perhaps, the strongest contributors. The dynamic nature of IDHTs may best be understood by an open systems model (Katz and Kahn, 1978) encompassing the interpersonal relations, group dynamics, and organizational issues affecting team behavior. The IDHT is a constantly changing organism with integrated interacting elements which are affected by and respond to environmental stresses (Beckhard, 1974a).

Research and writings on IDHTs have been directed primarily at three areas: 1. the interpersonal or interprofessional area as in studies on communication skills (Frank, 1961), interpersonal perceptions (Ducanis and Golin, 1979), leadership skills (Horwitz, 1969), and personality types (Mc Cauley, 1975; Pfeiffer and Woodward, 1984); 2. the group dynamics area as in studies and writings on group decision-making (Bem et al., 1975; Rubin and Beckhard, 1972), group risk taking (Teger and Pruitt, 1967), and conflict management (Eichhorn, 1974; Garner, 1983); 3. and the organizational/environmental area as in Fry's, (1974) look at the impact of interdisciplinary teams on organizational relationships, and as in Beckhard's (1974b) treatise on the organizational implications of team building.

Other authors (e.g., Rubin and Beckhard, 1972; Horwitz and Thomas, 1978; Parker, 1972; and Kane, 1975) have well performed the task of delineating the essential elements of health care teams. However, they fall short of organizing them into a framework, such as the one Indik (1968) proposed for organizations; a framework which could be used to organize research findings. Halstead (1976) attested to the proliferation of health team literature in the twenty-five years prior to 1976. However, he found the team effectiveness studies inconclusive and suggested that team care would remain largely a matter of faith without further studies. There has not been much progression in the acceptance of team effectiveness studies in the past 9 years.

What is lacking is a model which includes the elements of teams as they relate to each other, to the team, to the organization, and to the environment

outside the organization. Without a common model from which to work, IDHT researchers could remain like the proverbial blind men who describe different parts of the elephant. The parts may be understood but, viewed individually, cannot describe the whole organism.

Because of the complexity of an IDHT's internal and external environment, the framework which captures it must be multidimensional. It must allow for the pragmatic nature of the organization which houses the team and recognize the rapidly changing intra and interorganizational environment. It must encompass both the internal relationships and external factors affecting dynamics of the team. It should define the entity of interdisciplinary, address the developmental phases of interdisciplinary team function, and view teams as organisms which have the potential to survive over time. Finally, it should allow for the effects of environmental influences on the team, experienced as both positive and negative stress.

The idea for development of a conceptual model for IDHTs occurred as a result of observing a large interprofessional IDHT* over a period of nine years. The team developed and progressed through many stages, encountered internal and external conflicts, and dealt with almost constant changes in personnel. The team has survived and continues to develop and function in an interdisciplinary manner. This team has been the working model from which the conceptual model proposed in this paper emerged.

II. COMPOSITIONAL FACTORS

The central assumption in this compositional outline of the IDHT is that the team controls the power for its internal decision making. It is this element which defines the team as interdisciplinary, i.e., having the capacity for interdependent and collaborative decisions which are relatively free from external control. The assumption is that a functional IDHT has this capacity, and has developed sufficiently so that control of decision-making power is not held by only one or two members of the team and the sense of having power for decision-making is perceived by every member of the team. A functioning IDHT can take many forms, can have a variable number of disciplines, but members must feel free to engage in interdependent collaboration.

Team researchers most commonly refer to three sets of compositional factors which influence team development and survival: 1. personal/professional factors; 2. internal/team factors; and 3. organizational factors (Eichhorn, 1974; Baldwin and Tsukuda, 1984). For each of these factors, (Figure 1) there are three environmental levels: 1. the micro/team level, 2. the organizational/management level, and 3. the macro/external forces level; and two dimensions: 1. structure and 2. process which influence each factor. The three compositional factors are

*This team included the disciplines of nursing, social work, internal medicine, psychiatry, dietetics, pharmacy, occupational therapy, physical therapy, speech pathology, and audiology.

FIGURE 1

INTERDISCIPLINARY HEALTH CARE TEAM COMPOSITIONAL FACTORS

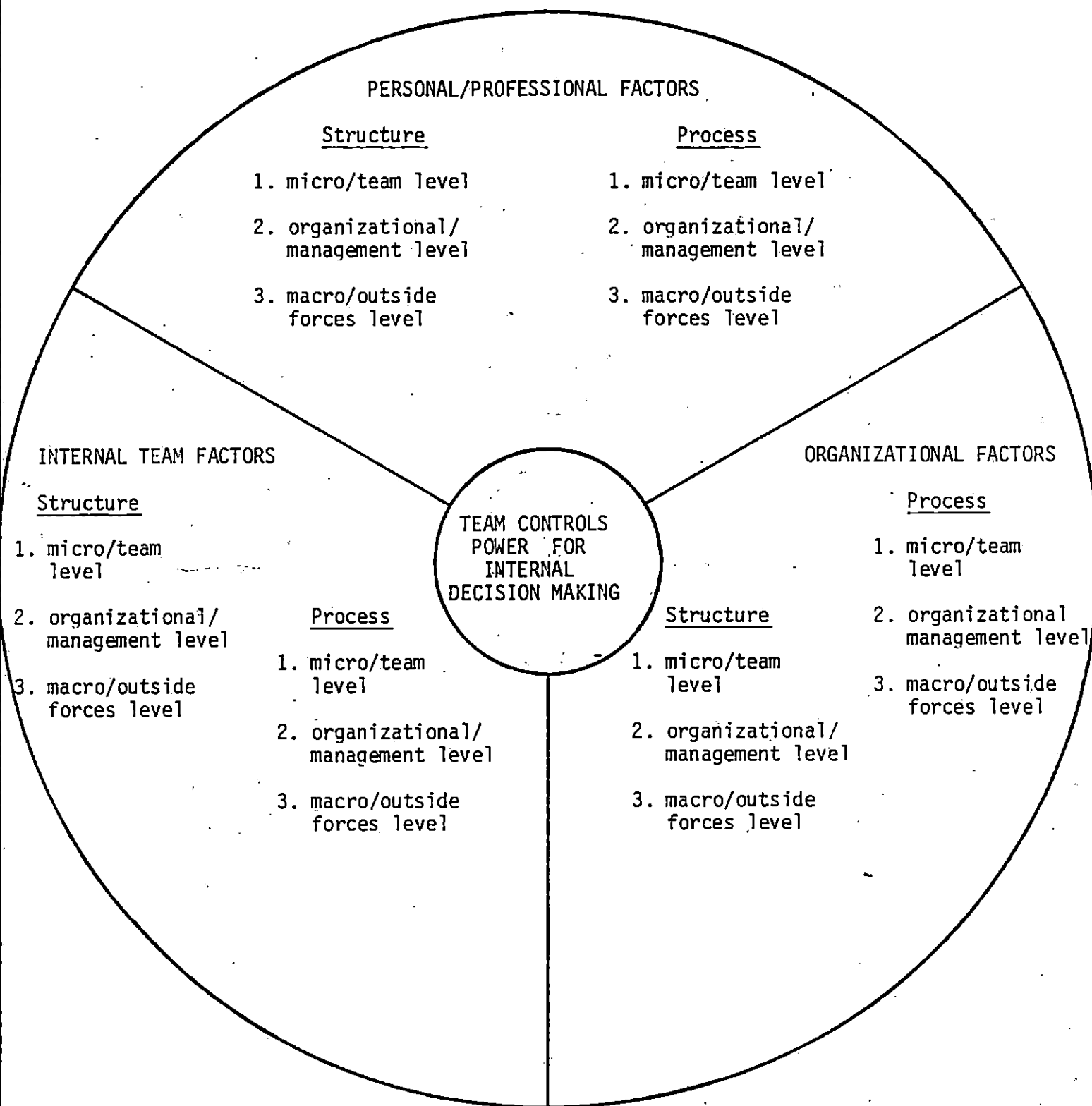
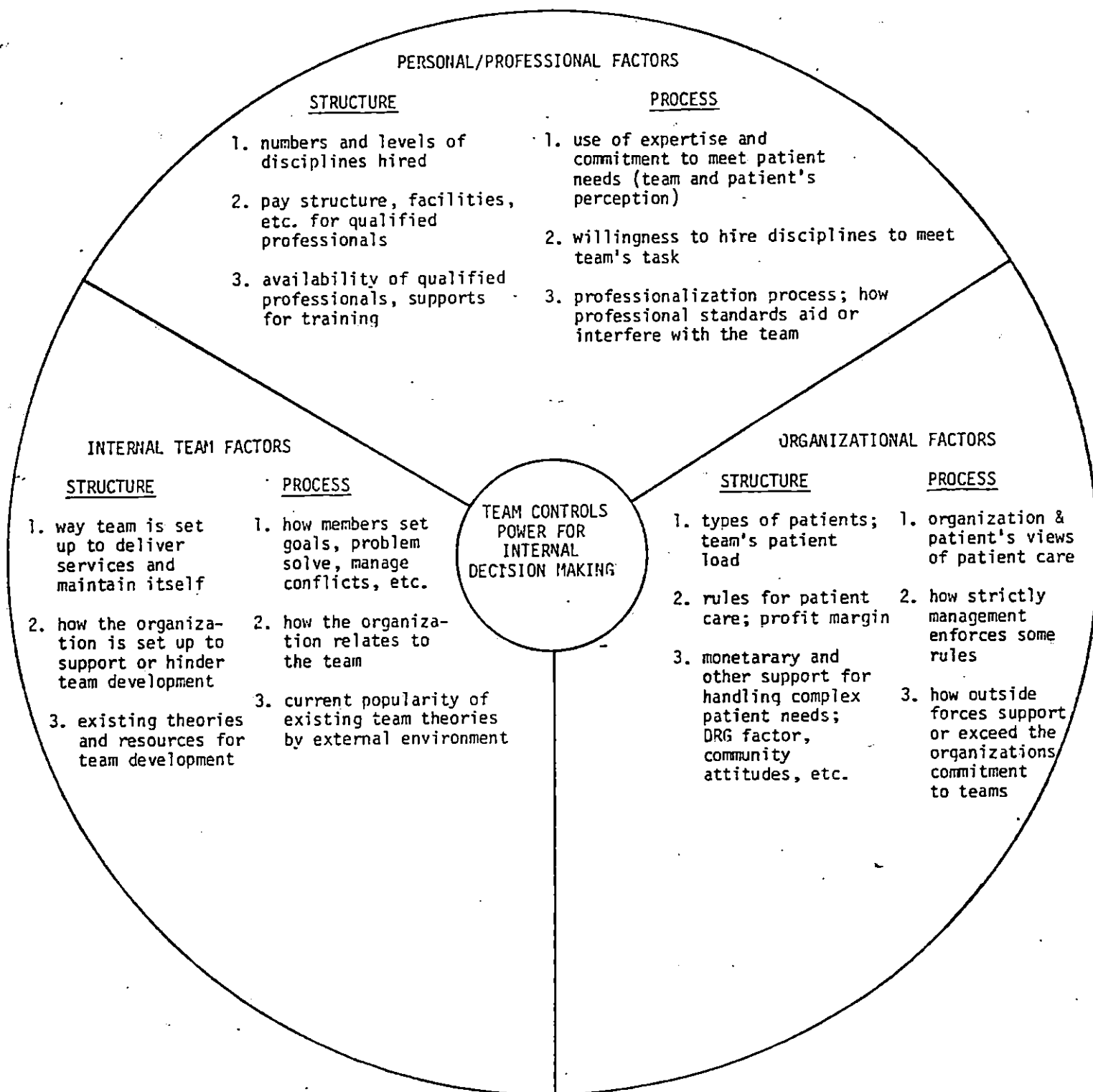


FIGURE 2
INTERDISCIPLINARY HEALTH CARE TEAM COMPOSITIONAL FACTORS

PROBLEM: Assembling a team to address the needs of a complex patient population



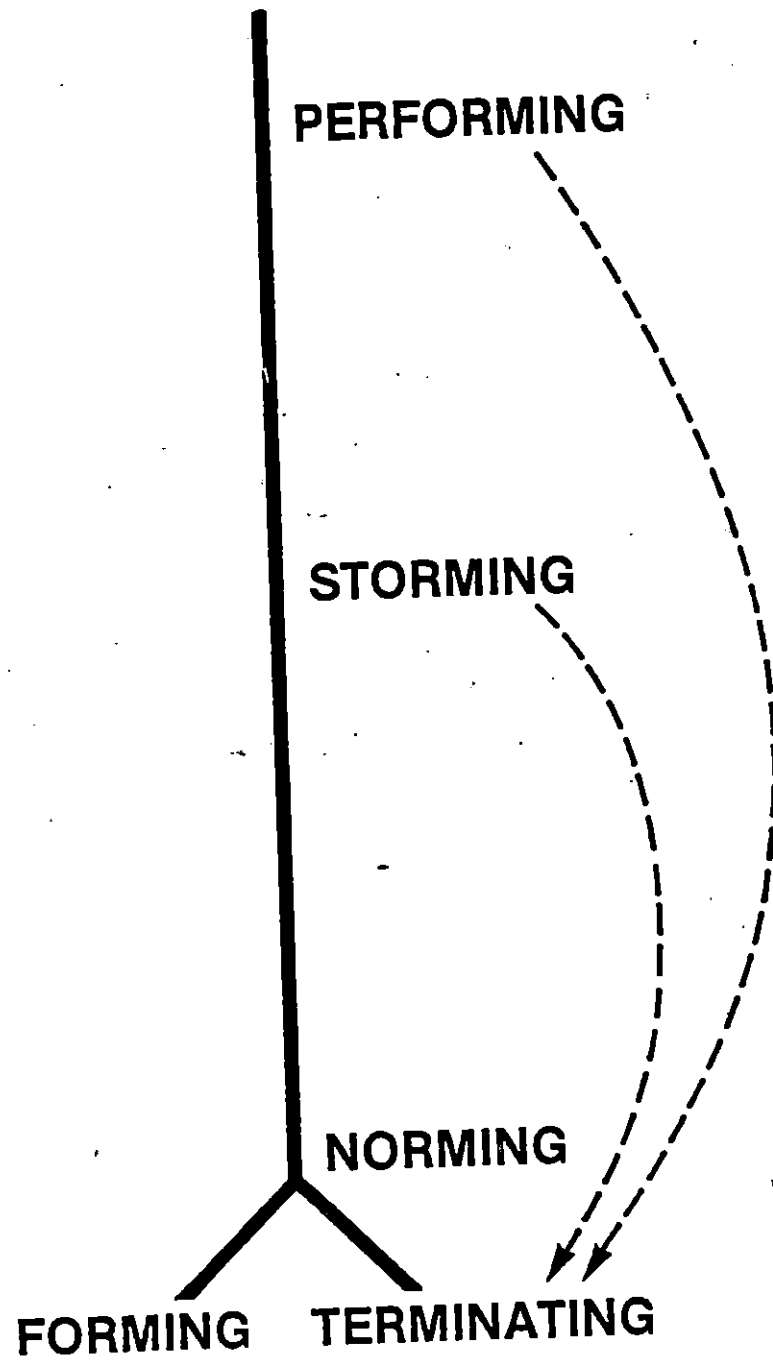
similar to the three areas of team research and writing previously described. The micro/team level is chosen as the first level because individual personalities and motivations in themselves are not a concern. It is the behaviors and interactions of those personalities as they relate to each other and to the performance tasks of the team which have an impact on the team. This first level concerns itself with the organization and interaction of the team members. The organizational/management level is the second level and is concerned with the manner in which the organization is structured to support or check the function of the team. The macro/external forces level involves forces outside the institution which affect the flow of resources in the form of money, political support, supply of professional and other personnel, etc.

Structure, as one of the two dimensions, refers to the way the team is organized, i.e., the composition or arrangement of factors at each of the three levels, within each of the three factors. Process, as the other dimension, refers to the continuous events and interactions which take place within the team for each of the three levels and factors; e.g., how members set goals, problem solve, and manage conflicts is a process dimension at the micro/team level and is an internal team factor (Figure 2). As team problems arise, the compositional factors can help identify the variables which might be contributing to the problem.

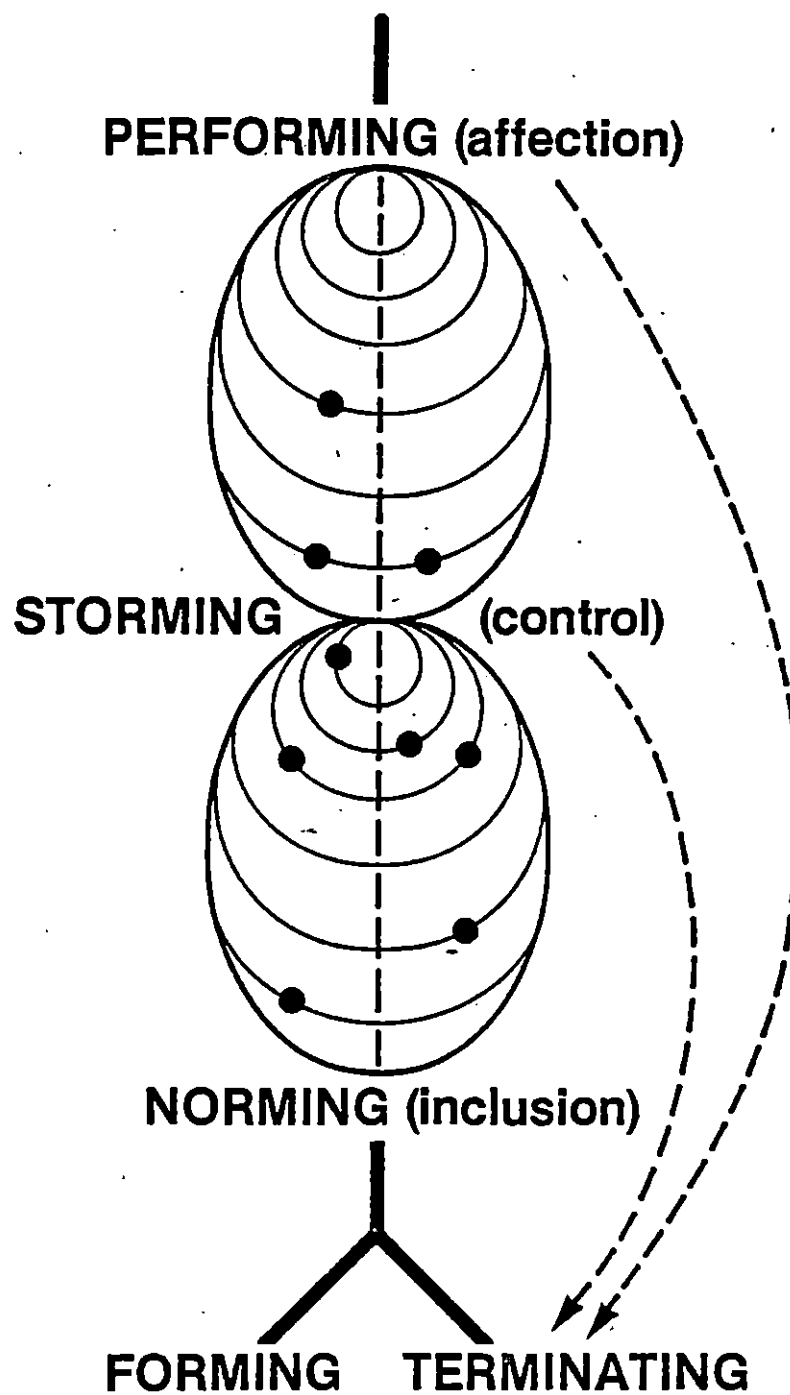
The stages of team development have been outlined by numerous authors (Shein, 1969; Gray and Nichols, 1979; Eichhorn, 1974; Brill, 1976) using remarkably similar concepts (Drinka and Ray, 1984). For simplicity, the terms chosen for this paper are those of Gray and Nichols (1979): Forming, Norming, Storming, Performing, and Termination (Figure 3). The initial stage of Forming is characterized by team members physically associating with and categorizing each other according to personal expectations of individuals and their disciplines. The Norming stage is characterized by mistrust and an inhibition of individual differences. Disguised power struggles occur as members try to establish their defined roles. The third stage, Storming, is characterized by the emergence of individual needs or of the conflicting needs of members. These needs are identified and openly addressed. Stage Four, Performing, represents the use of individual differences to define new roles and produce creative solutions to patient problems. As the performing stage is reached, team members need less help from a third party to address conflicting needs. In Group Dynamics Theory, the stage of Termination is based on the assumption that the team will eventually dissolve. In this conceptual model, this stage more often refers to individuals who may terminate from the team during any individuals or team stage. The team and individuals within the team can progress or regress through any or all of the stages, including termination.

Figure 4 includes Schutz's (1966) three stages of interpersonal behavior which occur during the process of group formation; i.e., inclusion, control, and affection. These stages correspond to those of Norming, Storming and Performing (Drinka and Ray, 1984). This figure demonstrates the progressive paths through which individuals must pass to become part of a functioning team. The dots represent team members who can progress or regress at different rates in the life of the team.

STAGES OF TEAM DEVELOPMENT



A MODEL FOR INTERDISCIPLINARY TEAM AND INDIVIDUAL MEMBER DEVELOPMENT.



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1984

Figure 5 is a three dimensional representation of all of the Model's components. It includes the elements of both positive and negative stressors for the team. Figure 1 is inserted through the center of the model. Individuals and teams selectively experience elements from Figure 1 as stressors for their team. Stressors may be perceived as positive or negative, or may change polarity based on the numbers and types of stresses a team is experiencing. It is conceivable that a team could experience neutral stress in all areas for a period of time. One speculates as to the length of time a team could remain in a neutral stress state without the neutrality itself becoming a negative stressor.

III. DISCUSSION

Halsted (1976) found the team effectiveness studies from 1950 to 1975 largely inconclusive. Ten years later, as issues of cost containment rise to the forefront of health care issues, there is increasing pressure for teams to prove their cost effectiveness. Perhaps, because proving effectiveness of any aspect of health care teams is such a complex venture and has not been adequately accomplished, the organizational interest in IDHTs has waned from its peak in the 1970's. However, health professionals from different fields continue to work together. The greying of America and the growing needs of the at-risk frail elderly increasingly demand that professionals from many disciplines work together. Rising health care costs demand that they do it effectively and efficiently.

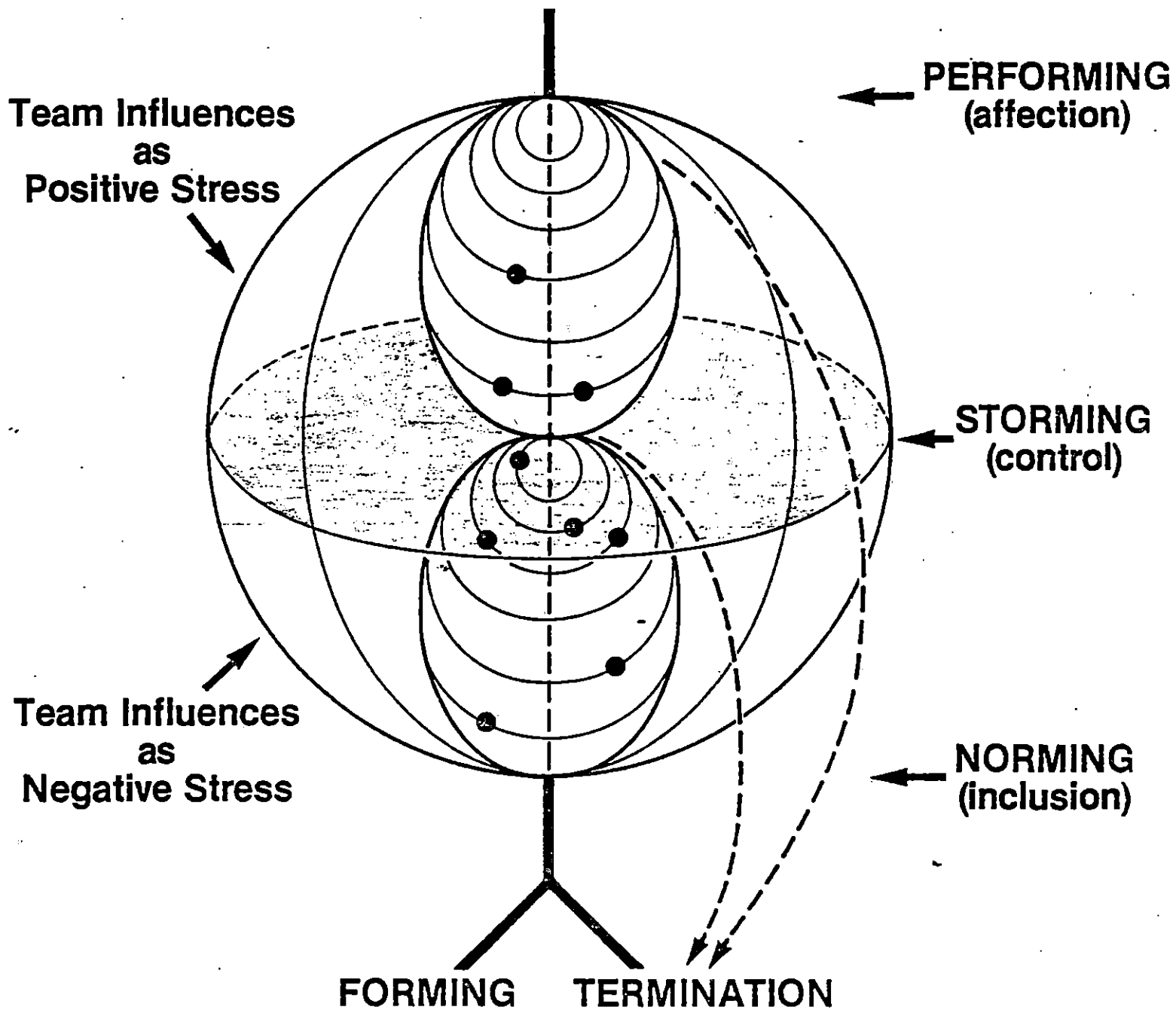
Because health care delivery has had a unique history, the organizational structure in health settings where MDs have a great deal of formal power is different from other organizations. Physicians and scientists are separated from other health professionals in experiencing administrators' formal authority over them (Weisbord, 1976). Because the culture of most health care organizations is resistant to change (Barko, 1983) and because the technical outcome of health care tasks is perhaps less predictable than other organizational tasks, health care settings are different from other organizations. Weisbord's (1976) classic article on why organizational development hasn't worked in health settings was followed by Barko (1983) who speculated as to why organizational development still hadn't worked: it still had not been able to demonstrate its value.

Perhaps the reasons why organizational development has not worked in health settings and why excitement about interdisciplinary interprofessional teams has waned are both related to the lack of an acceptable conceptual model which encompasses the complex nature of IDHTs.

Measures for testing a team's development and impact on the health care organization, and the team's impact on the patient must be integrated with the vast number of variables influencing the team. Are certain factors more significant stressors in specific developmental team stages, e.g., the personal/professional factors in the Norming stages? How significant are these same factors as stressors when new members are joining an established team? Are certain levels of stressors such as organizational process level stressors vs. team process level stressors more often viewed as negative by

FIGURE 5

A MODEL FOR INTERDISCIPLINARY HEALTH TEAM DEVELOPMENT AND SURVIVAL.



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the team? Which factors and elements are most important in determining whether the organization views the team as successful? Without an adequate conceptual model, the significance of studies like this cannot be fully understood.

Ten years ago Halstead (Kalz et al. 1976, p. 60) stated "... there are thousands of articles that trumpet the virtue of team care based on theory and anecdotal experience. But, using the team approach as a rigorous tool and looking at it in terms of objective, well controlled studies there is very little guidance in the literature." In 1985, there is still very little guidance in the literature. That guidance needs to come in the acceptance of a well developed conceptual model. Perhaps, this proposed IDHT conceptual model can be a major step in the process of accepting a model which accommodates for multiple variables; one which will be tested and refined by ongoing research.

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A Negotiated Process Model for Lay-Professional
Group Interactions
Introduction

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This presentation will describe a Negotiated Process Model for lay professional group interactions; including (1) some background information, (2) the model as conceptualized, (3) and its use in the field experience. In the summer of 1984, partial funding was received from the Interprofessional Education Committee, of the University of Illinois at Chicago, by a faculty group to develop an interprofessional course in Women's Health using a Primary Health Care approach as defined by the World Health Organization (1978). A major goal for the course was to develop an alternative practice model or approach utilizing an interprofessional health team based on primary health care concepts to meet health needs of urban women in an industrialized country. One of the course objectives was to teach health professional students to function as a primary health care team in working with a group of community women.

We were fortunate to have a group of community women from a Latina women's organization in a Mexican community, within Chicago, who were interested in working with us.

The exploratory work in 1984 led to the development of a Negotiated Process Model which was used in the summer of 1985 in the Women's Health course field experience. This course is more fully described in another paper in these proceedings (Dan, A., Keys, E., Reeves, J., Hennein, S., Holden, J., and Petty, J. "An Experimental Course in the Application of Primary Health Care Concepts to Women's Health in an Urban Setting"). A research study was undertaken to describe the interactions between a health care team (professional) group) and a lay community group when they utilized the Negotiated Process Approach. The study addressed the following research questions:

- 1) What dynamics occur between a lay group and a professional group when they use a Negotiated Process Approach to resolve a health promotion or disease prevention health care need for a given community?
- 2) What is the utility of the Negotiated Process Approach?

Study data have been collected and are currently being analyzed. The present paper focuses on the conceptual model with some preliminary impressions of its use in practice.