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LEADERSHIP AND CONFLICT
THE FAILURE OF PARTICIPATORY DEMOCRACY ON
REHABILITATION TEAMS

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Introduction

A successful rehabilitation effort depends on the ability of a diverse group of professionals to function as a coordinated, integrated team. Prior to discussing issues related to conflict, leadership and the role of democracy on rehabilitation teams, it would be helpful to highlight the uniqueness of interdisciplinary teams in the rehabilitation setting. In contrast to most medical areas, rehabilitation specialists profess to be comprehensive -- dealing with medical and physical issues along with a host of psychological, social, and vocational concerns. The team members usually include a nurse, physician, psychologist, social workers, speech therapist, physical therapist, and an occupational therapist. Not uncommonly, prothetists, orthotists and vocational counselors will be involved. These different professionals offer the unique training and insight necessary for comprehensive rehabilitation. To a large extent these skills are not interchangeable. For example, most of what a physical therapist does can only be done by a physical therapist. The mere coordination of these varied activities rivals the complexity of tasks confronted by interdisciplinary teams in any medical or social service setting. Furthermore, rehabilitation settings are emotionally charged environments having many similarities to mental health facilities. Unfortunately, rehabilitation professionals rarely have the time or training to deal with these issues as they would be dealt with by a psychiatric team.

A rehabilitation patient may be an elderly woman -- living by herself in a two-story home -- who suffers a stroke, is subsequently unable to walk, and has significant problems with mobility, self-care, speech and perception. In a similar vein, a young man who becomes a quadriplegic following a motor vehicle accident; an obese, inactive woman who must have a leg amputation; an elderly man with Parkinsonism who suffers a fractured hip; or a two-year-old girl who has a closed head injury following an accident in which her mother was severely hurt, all present a myriad difficult physical and psychological issues. Common concerns in a rehabilitation setting range from technical areas such as strength, range of motion, muscle tone, mobility, self-care, and cognition to more diffuse issues such as reactions to disability, motivation, self-worth, sexuality and finally relationships with spouse, family and friends. Needless to say, all of these issues impact on vocation, discharge plans, and community reintegration. This cauldron of concerns makes the work of teams in a rehabilitation setting quite difficult.

Rehabilitation teams are accustomed to dealing with these complex issues and have done relatively well in providing comprehensive care. Several studies have shown or suggested that more effective rehabilitation occurs in a specialized unit than when the same services are offered on a general ward. In a controlled study of rehabilitation of stroke patients based in Edinburgh, Scotland, Garraway found that functional independence was greater and length of hospitalization shorter for patients treated on a stroke unit as compared to those treated on a medical ward(1'2). Two additional studies compared patients treated on special stroke rehabilitation units with those who received therapy on general medical wards(3,4). While differences in independence for activities of daily living were small, a greater percentage of patients who were living at home had received rehabilitation on the stroke unit. Halstead reviewed research efforts on team care in chronic illness over a twenty-five year period(5). He concluded that the majority of studies showed coordinated team care improved outcome in one or more areas when compared with control groups.

The use of diverse professionals in a coordinated fashion is nearly a sacrosanct idea in rehabilitation(6). The founder of modern rehabilitation medicine, Dr. Howard Rusk, began using and coordinating the efforts of physicians and non-physicians alike in providing rehabilitation services to the disabled during World War II(7). From the work of Dr. Rusk and others during World War II and later at New York University, a sense of mission has developed to provide comprehensive care for the disabled. This philosophy of attending the physical, psychological and vocational concerns characterizes most rehabilitation settings and distinguishes physical medicine and rehabilitation as a medical specialty.

Despite the admirable accomplishments which have been made for the health care of the physically disabled and the use of a comprehensive team approach, many problems are encountered with the team approach to rehabilitation. Dr. Jerome Siller expressed the frustration of many rehabilitation professionals in the feature article of Rehabilitation Literature in October 1968, "I am always impressed with the contrast between the verbalization of the importance of a team approach and the actual operation in rehabilitation settings. One is reminded of a nursery school for two-year-olds where despite physical proximity everyone is busy with his independent play"(8). Striking a similar theme, many have complained that rehabilitation teams are all too often multidisciplinary rather than interdisciplinary(9-11). Still others have distinguished teamwork from team work(12).

A certain paradox arises between the stated importance of rehabilitation teams and their actual functioning. A brief survey of five standard texts of physiatry(13-17), the medical specialty of rehabilitation medicine, revealed few references to

team management. Only one of the five texts devoted an entire chapter to team care(14). Another discussed teams within the context of rehabilitation nursing(15). The others(13,16,17) devoted less than a half-page specifically to teams. A chapter by Anderson in Medical Rehabilitation is exceptional for being a good, concise description of how a team should function. However, important issues such as leadership, communication and conflict are rarely if ever acknowledged as issues worthy of more investigation and discussion in the standard medical rehabilitation textbooks. The importance of a team approach in rehabilitation appears to be accepted more on faith than on research and discussion. This paper will attempt to explore some of these important issues on rehabilitation teams.

Participatory Democracy

"Participatory democracy" is a phrase which grew out of the social unrest of the 1960's and particularly the Port Huron Statement of the Students for a Democratic Society in 1962(18). The phrase captured the zeitgeist of reform for many in the 1960's. Generally, it referred to a type of personal involvement in grassroots political action based on a consensus in the face of an insensitive, detached bureaucracy. While it is perhaps a little hyperbolic to use this term in the context of interdisciplinary teams, notions of democracy and a type of participatory democracy have influenced many early proponents of team work, who frequently were also involved in other political activity. Team members commonly favor notions of democracy, equality, and decision making in the context of teamwork. As will be explored in more depth, such ideas are probably not relevant to the context of modern health care delivery(19).

Many early writers on health teams endorsed the ideals of a democracy shaping the processes of "decision-making, conflict-resolution, communication and leadership on the team"(20). In specific reference to rehabilitation teams, Renee Noren proposed a democratic orientation, equalizing power and responsibility. She writes, "The full potential of a group will only be reached with a democratic approach rather than by a single chief or rehabilitation specialist...No single professional will make a major addition, subtraction or change in the patient's treatment without consulting the other team members"(21).

In 1972, Drs. Banta and Fox studied a primary health care team in a poor area of Boston which had been influenced by ideas of a democratic structure(22). Instead of assuming physician dominance of the treatment and the team, the person with the greatest rapport with the patient and knowledge of the social situation was supposed to be in charge of any specific case. The researchers found that team members of one profession were unsure of other members' roles and tasks. Conflict occurred when

different professionals shared common territory, a frequent occurrence given the philosophy of community health care. Social workers and public health nurses had tense relations because of differences in perceived roles. This tension was heightened by differences of age, dress and socioeconomic class. Many physicians were viewed as having a disruptive influence. The investigators emphasized the importance of role clarification and flexibility with regards to professional responsibilities. They also observed that these problems were not merely cognitive or organizational, but a question of deep-seated attitudinal learning which needed to be dealt with in an ongoing dynamic process, preferably with outside professional help.

Carrying notions of participatory democracy to one logical conclusion, some have proposed that the patient be the team leader(23). While recent attempts by Halstead, Rintala and others(24,25) to understand and increase patient participation in the team process, and the hence the rehabilitation course, are strongly endorsed and encouraged, improvement in patient participation should not be confused with the need for professional direction and coordination. Patients have neither the skill nor the objectivity to be captain of the team. Discussing this issue from a philosophical perspective, Purtillo asserts that "while (the patient's) self-determination is a valid moral guide to good rehabilitation outcomes, it is probably not a sufficient one...Constraints on self-determination should...be guided by concern for the candidate's welfare."(26). Hence, "limited paternalism" is ethically justifiable and a practical necessity.

Among team members, notions of democracy and self-determination evoke strong emotions which extend beyond the specific issues of health care teams to many societal problems. As painfully demonstrated in the Columbia Point experience described by Banta(27), when goals become too broad and vague, the specific concerns of the health care organization may be inadequately and ineffectively addressed. For some it may be useful to distinguish a social democracy from a political democracy(28). From this perspective, individual team members have a right to speak regardless of their position in the hierarchy and their ideas should be evaluated on the merit of the ideas themselves. This discussion on democracy illustrates that theories on team functioning will only be meaningful when the given socio-political realities are taken into account. In her comments on democracy and interdisciplinary teams, Kane(29) concludes, it is probably best to stay away from concepts of democracy since the emotional connotation is apt to evoke associations not specifically related to health care teams.

Conflict And Professionalization

Professionalization and the related issues of professional

roles provide an important backdrop to understanding how teams function. Generally, each team member comes from a unique professional background encompassing its own body of values, skills and knowledge. The investment in one's professional belief system often approaches the intensity of a religious dedication(30-32). No wonder conflicts arise when team members are asked to share common areas with team members of another profession, to bend the definition of what one does, and even to acknowledge that the agenda from another's profession might be more appropriate in a given situation. Compounding the problem, most rehabilitation professionals have had little if any training on how an interdisciplinary team functions. In particular, the physiatrist, the traditional team leader, typically has little familiarity with the dynamics of team process prior to becoming the leader. Team members with a rigid sense of professional identity will probably become anxious when placed in the situation where roles are flexibly interpreted and areas of expertise overlap(33).

Many studies have shown that members of one profession frequently have a poor understanding of the activities of another professional group even in a related field. Kane reviewed twenty-seven studies and found "little congruence between the way a profession defines its role and the way others define it"(34). Horwitz maintains that it is important for each team member "to undertake the hazardous expertise of acquiring a measure of working familiarity" in the areas of expertise of other team members(35).

Each team member has several "reference groups"(36). Reference groups include profession, cultural background, and in this context, team membership. While teams are praised as essential to a comprehensive rehabilitation program, the relative allegiance to a particular team usually lags behind the allegiance to the department (profession) and to the hospital administration. When a conflict occurs between various reference groups, we tend to side with the one to which we have the stronger ties(37).

To avoid the pitfalls of a narrow professional perspective, several writers have suggested a reorientation away from professional roles and traditional job responsibilities and towards the specific tasks of what needs to be done(38). In rehabilitation issues are sometimes seen in reference to the specific task such as mobility, transfers, psychosocial adjustment, and communication instead of specific areas such as physical therapy, psychology, or speech. A word of caution is in order, however. This reorientation involves much more than changing labels, but a reformation of roles and relationship.

A danger exists in naively interpreting this reformation of roles to tasks. This naivete arises from a confusion of symptoms

and disease process, to use medical terminology. The pathophysiology stems from ingrained characteristics of professions and related issues of status, power, economics, and sex. It is more than a difference of opinion on, for example, the preference for one baseball team over another, and perhaps more akin to religious and political differences. The depth of the problem reflects the difficulty of change. And yet, progress has been made and should continue. The over-riding common commitment should be to quality care.

Teams are also hampered in their work by the influence of the relationship with the hospital administration. Prestige, salary, employment decisions, and scheduling are usually made on the departmental level. In an administrative sense, physicians report to physicians, occupational therapists report to occupational therapists, psychologists to psychologists and so on. Team membership is decided on the departmental or administrative level, and staffing is usually done at the convenience of the department. For example, is it fair to patient or therapist alike to occasionally rotate a physical therapist who treats primarily strokes or spinal cord patients to chronic pain patients? The purpose of team meetings fades when a substitute therapist reports for a regular team member. Even information about hospital-wide social events tends to flow through the departments. At times, the team appears to be of secondary concern to the hospital administration and the professional department. It has been suggested that the mere existence of teams "calls into question many of the established procedures and relationship of their parent institution"(39). Modifications of these social relations are likewise difficult, but could enhance team functioning.

Team Leadership And The Physician

The interrelated issues of the role of the physician and the nature of team leadership are crucial to understanding how teams function in a rehabilitation setting. Traditionally, physicians have been granted the leadership role by the larger organization. With some justification many observers of interdisciplinary health care teams, particularly advocates of a democratic orientation, blame this professional dominance for many of the difficulties on interdisciplinary teams(40,41). The physicians' role in the leadership position should be explored and changed as appropriate and possible. Non-physicians need to be reminded, however, that naive or hostile proposals for change are apt to result in either having the suggestions ignored or the maintenance of a defensive posture on the part of the authority figures, usually the physicians. In either case, little constructive change will result.

Physicians have clear ethical, legal and economic responsibilities in patient care. Society generally holds the

physician responsible in health care settings. While anyone can be sued, it is typically the physician who must bear the responsibility for mistakes. Furthermore, the physician's caseload is likely to determine the volume of work and extent of reimbursement. These responsibilities are not written in stone and should be discussed and debated, but understandably, extend beyond a discussion on interdisciplinary teams. The functional dominance of the physician in health care delivery will probably continue for a long time(42,43) and should be acknowledged in any attempt to understand and improve the team approach in rehabilitation.

Physicians, on occasion, have been influenced by democratic notions of team functions in a peculiar way. We have seen a "pseudodemocratic" style of leadership in which the team ostensibly functions as a democracy. When democracy is applied in this curious form, the direction and authority necessary for accomplishment of either task or maintenance goals are not provided. One gets the sense that the pseudodemocratic style may arise from a poor understanding of what the other team members really do. Frustration, fragmentation and ineffectiveness are experienced by team members in this circumstance. The ultimate hypocrisy of this style surfaces when a team decision or strong sentiment is reversed by the team physician in a seemingly arbitrary manner with little explanation offered.

Effective leadership of an interdisciplinary team involves a diverse and loosely related set of skills, reflecting different aspects of leadership. Parker(44) proposed five areas of leadership encompassing patient management, team management, primary patient relationship, charisma, and medical decision making. Typically, a designated leader excels in some areas more than in others, and different team members will take on one or more of the other areas of leadership function. Commonly, the physician will lead many of the goal-directed activities and other team members such as psychologists or social workers will perform functions related to team building and team maintenance. Similarly, patients will experience the leadership of different professionals as they progress through their rehabilitation course. Initial concerns may focus on medical and nursing issues, while later on physical and occupational therapy activities dominate. Finally, speech and vocational rehabilitation interests may be emphasized. Thus, the leadership of a rehabilitation team is a complex process.

While formal leadership of an inpatient rehabilitation team is usually bestowed on the physiatrist by the administration, physicians are not universally the chosen leaders of interdisciplinary teams. Examples from pain management programs, mental health settings, and burn units have shown that teams can function well with non-physician leaders. However, if the physician is not intimately involved in the team, the team's

ability to integrate a comprehensive approach will be severely hampered. The peculiarities and complexities of inpatient rehabilitation will always demand active involvement by the physiatrist, whoever the leader is.

Leadership functions should entail both specific task accomplishment and team maintenance(45). Needed skills thus include both goal-directed abilities and interpersonal skills(46). Ultimately, the team leader should be a facilitator of the achievement of common goals(47).

Earlier, the idea of refocusing activities away from an orientation of professional roles and towards meaningful tasks was explored. In a similar fashion, team leadership activities could be refocused away from the role of leader as a status or position towards a function necessary for teams to operate effectively. The patient experiences different "leaders" in rehabilitation at different times. However, a reorientation of the nature of leadership can also be easily misinterpreted. The varied leadership functions should be distinguished from the need for a leader who provides team direction, and who commands authority from team members and the administration. Democracy does not work; a leaderless team is a myth.

Team Tension as a Vital Sign(48)

Physical disability in rehabilitation usually represents a major upheaval in a patient's life. Interrelated issues of dependency, self-worth, sex and physical health abound. Likewise, the family's social system is profoundly disturbed by the sudden onset of a major physical and sometimes cognitive disability.

Teams experience the emotional turmoil inherent in the rehabilitation setting. As Gunther(49) and Nason(50) have observed, staff anxiety may reflect intrapsychic and interpersonal turmoil of the patient. One tends to emotionally identify with that aspect of the patient's problem which has some sort of personal meaning, even though the team member may not be conscious of this personal meaning. A physician could be reminded of his or her father's death and be overly anxious about medication compliance. A social worker may acutely feel the family's anxiety for the recently disabled parent returning home along with her personal concern of her father-in-law's need for a nursing home placement. Likewise, the occupational therapist is tuned in to the patient's frustration with his inability to dress himself and the therapist may have a hard time teaching the family who remind her of her own relatives. The physical therapist sees another side of the patient's depression in his frustration with ambulation, and feels put down, like a child, with the early discharge date set by the physician. And thus, the patient's distress may have personal associations for the

staff. Caregivers are also victims.

On a more complex level, team dynamics interact with and are influenced by the patient's own psychodynamics. Typically a borderline patient will split team members into "good guys" and "bad guys." Similarly, a very regressed patient will evoke personal reactions from individual team members such as empathy, fear, and rejection. Understandably, a team conflict may reflect the internal conflict of the patient.

There is a tendency to discount these emotional components when working in a rehabilitation setting. On rounds, physical concerns tend to be overemphasized to the detriment of psychosocial areas(51). Several researchers have suggested that the massive psychic trauma which frequently follows major physical disability tends to be disavowed by patients, family and staff(52,53).

As Gunther(54) so eloquently describes, emotional distress is an "inevitable outcome of significant involvement with patients." This distress affects team function and patient care profoundly but is frequently not acknowledged. It is useful not only to accept staff frustration as a necessary component of significant patient involvement, but to realize that these tensions may also provide a significant insight into how the patient is doing -- a vital sign -- as proposed by Nasan.

Conclusion

The rehabilitation of the severely disabled occurs in an exceedingly complex environment of technical and emotional concerns. This complexity appears to be poorly understood by both rehabilitation professionals and experts on interdisciplinary teams. Physical Medicine and Rehabilitation is unique in medicine because of its long-standing commitment to comprehensive care and the use of interdisciplinary teams. This emphasis has been shown to be fruitful. Research has demonstrated improved outcomes on rehabilitation units compared to more traditional medical settings(55). Other fields of medicine and other areas of health care delivery could learn from the rehabilitation experience.

The holistic approach inferred in comprehensive, interdisciplinary rehabilitation is, to paraphrase an old adage, more than a sum of its parts. The tunnel vision which specialization has produced needs to be kept in check. Not only do professional roles interfere with the operation of a team, the hospital administration creates obstacles which, though frequently inadvertent, impede work in teams. At best, the "teamwork" of rehabilitation is often multidisciplinary and not interdisciplinary. More emphasis needs to be placed on the team; the team as both a reference group for individual team members

and as the style and source of patient care.

Flexibility is an important theme in improving teamwork. Some have found an orientation towards tasks and de-emphasize of professional roles to be useful. Patients do not present their problems in separate professional categories. What is accomplished in a rehabilitation setting is more important than who does it.

With regards to leadership, there is a need for specific leadership which gives the team direction and facilitates the team process, as well as an appreciation of the diverse functions of leadership. Such leadership, of course, is not limited to physicians. There are many examples of health care teams with non-physician leaders. Physicians and health care administrators need to be open to other alternatives. Likewise, non-physicians must remember the medical dominance in health care will probably, for better or worse, continue for a long time and proposals for change are doomed to failure if these political realities are ignored. Physicians, too, need to change attitudes and perceptions of health care delivery and become more cognizant of the need for teamwork and more knowledgeable and skilled in accomplishing it. These long-standing and deep-seated social relations change slowly, but should change as needed to enhance the comprehensive rehabilitation of our patients.

And finally, tensions and conflict will always be issues with interdisciplinary teams, particularly in rehabilitation. Conflicts arise not only from sociopolitical issues, but from the psychological circumstances of the rehabilitation environment.

Rehabilitation teams undoubtedly will benefit by more familiarity and experience with the issues of interdisciplinary health care teams in general. However, given the unique complexity of rehabilitation settings, as rehabilitation professionals we will need to ultimately find our own solutions.

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