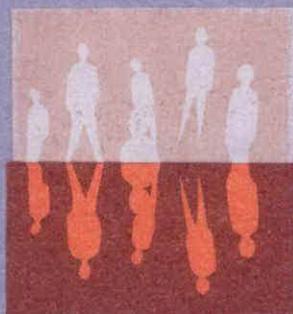


# interprofessional teamwork



by Rosalie A. Kane

The Division of Continuing Education and Manpower Development of the Syracuse University School of Social Work conducts manpower research, consultation, curriculum development, and offers training programs for all levels of social welfare personnel.

Please direct inquiries to:

Director  
Division of Continuing Education and Manpower Development  
Syracuse University School of Social Work  
Brockway Hall  
Syracuse, New York 13210

This monograph is part of a series of publications which addresses social work manpower issues. The Division is delighted that the distinguished educator and researcher, Dr. Kane, has allowed us to publish this significant study.

# interprofessional teamwork

by Rosalie A. Kane  
Assistant Professor,  
University of Utah  
School of Social Work

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## ACKNOWLEDGEMENTS

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R. A. K.

## FORWARD

Milton Wittman\*

Perhaps the best example of how a team should function can be described by the extremely complicated yet effective functioning of the human hand, with the five fingers articulated to perform the several tasks which can be done only with a full hand. Members of interprofessional teams function somewhat the same way. The cooperation and understanding of all are needed to create a pattern of successful functioning.

Since the first decade of this century, when social work began to emerge as a profession, there has been concern for interprofessional functions in several distinctive types of institutional service-delivery systems which employ social workers in a wide range of functions. These institutions involve medical and health care, including mental health, the correctional system, and more especially the court services, and the educational system all of which require several disciplines to provide effective service. With the progress of time there was increasing sophistication in the development, organization, and in the structure of interprofessional teams in psychiatry and medicine, in the correctional system, and in primary and secondary schools where school social work came into being. During the current decade there is immense preoccupation with the nature of interprofessional practice and implications for the clients served, for the community, and for the several professions and other components of the interprofessional teams. This study represents one specific effort to apply some systematic exploration to the literature on interprofessional activity, and to explicate the problems in the organization and delivery of services when these occur through the interlocking and coordinated functions of several professions.

In a recent British conference on the psychotic patient in the community, John Wing of the Maudsley Hospital quoted Elaine Cummings on three criteria for the preparation of the several professions for collaborative work. It is important for each member of the core professions in mental health to understand in depth the basic knowledge and theory applying in that individual profession. Second, it is important for each member of the core professions to know about the theory and philosophy which governs practice in the other professions. Third, it is important to be able to select from the full range of knowledge about human and social behavior the elements of understanding and action which make it possible to assist clients and communities to understand themselves and to move with confidence toward improved mental and social functioning.

This study has made a significant effort to compile knowledge from several disciplines about interprofessional teamwork in order to present a body of material which will be of use to the field in assessing how well the professions work together and in considering some of the problems that facilitate or hamper improved interprofessional communication and cooperation. In its review of the operation of 229 teams this survey provides a quantity of data about the composition and functioning of interprofessional teams in the delivery of social and health services. While the study provides no definitive answers it raises a number of provocative and ineluctable questions about the nature of interprofessional practice. These questions have direct implications for education and for practice. We are provided with means for examining further and considering in some depth the nature of service delivery aimed at resolution of social, health, and human problems which have proved so intractable and difficult to resolve in the face of what appears to be a rising amount of social and psychopathology in this country and in the world.

It is of no small significance that 1975 Federal legislation has considerable import for a much increased scope of services in community mental health centers throughout the United States. The community mental health center may in time be considered one of the important social inventions of the Twentieth Century. The centers offer some hope (not yet fully realized) for community-based social and mental health services importantly related to maintaining the mentally ill in the community rather than in isolated mental hospitals. This function cannot be achieved without interprofessional teamwork with a high order of productivity.

The study by Rosalie Kane offers some fresh insights gained from a review of the literature on interprofessional teamwork which will further thinking and analysis around team functioning. The study raises many questions for further exploration and analysis and it can only be hoped that other scholars will continue the examination in depth of interprofessional functioning as it relates to the delivery of human and social services.

\*Milton Wittman, D.S.W. is Chief, Social Work Education Branch, Alcohol, Drug Abuse, and Mental Health Administration, Department of Health, Education, and Welfare, Rockville, Maryland.

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## Chapter 1

### DEFINITIONS AND RATIONALE

The interprofessional team has indeed become almost a standard feature in the delivery of professional services. A logical rationale has been advanced for reliance on interprofessional teamwork; the arguments usually stress the inevitable interdependence among professionals concerned with human services in an increasingly complex society. With more sophisticated understanding of human behavior available to the professions, all professional groups are advocating interprofessional teamwork and improved interprofessional communication in the interests of the clients or consumers of service.

Social workers have been involved in interprofessional teams in the health field since the turn of the century (Cabot, 1909, 1919); writers commenting on social work in hospital or health settings. (Bartlett, 1961; Phillips, McCulloch, Brown, & Hambro, 1971; Upham, 1949) almost invariably emphasize the need for advanced teamwork skills. In the rehabilitation of the handicapped, a field almost ideologically committed to the notion of the "whole man," the interprofessional team seems to be the *sine qua non* of service (Horwitz, 1959, 1970).

In mental health practice, too, the team modality has flourished for decades, and social workers have been charter members (Levine & Levine, 1970). Early in the twentieth century, child guidance clinics developed the model of the psychiatrist-psychologist-social worker team (Powers, 1973); in theory, at least, each team member performed a fairly distinct role. These roles have become more blurred over the years, but the team idea in mental health has been expanded to settings such as hospitals (Abrams, 1969), day treatment centers (Williams, Dudley, & Guinn, 1969) and residential treatment centers (Kemp, 1971). Certainly the Community Mental Health Center movement flourishing in the 1960's has disseminated an ideal of interprofessional teamwork for the prevention as well as the treatment of mental illness (Caplan, 1964). The four basic professions in community mental health have been identified as psychiatry, psychology, social work, and psychiatric nursing (Smith, 1974) with a large cast of supporting professions including educators, clergymen, and many others.

Specialized health fields such as geriatrics (Brody, Cole, & Moss, 1973) and mental retardation (Stone, 1970) have advocated interprofessional teamwork, and, indeed, their knowledge bases are interdisciplinary in nature. Teams functioning in these fields seem to be hybrids of health and mental health, requiring both kinds of expertise. Teams may include combinations of physicians, psychiatrists, psychologists, social workers, nurses, nutritionists, occupational therapists, physical therapists, speech therapists, teachers, recreationists, and vocational counselors.

Although the health and mental health fields have perhaps accounted for most of the organized attention to the concept of interprofessional teamwork, other fields in which social workers practice have also posited a team ideal. The juvenile court has largely become an interprofessional enterprise (Brennan & Khinduka, 1971), while legal aide agencies have for sometime included mental health personnel on their staffs (Mueller & Murphy, 1965; Smith, 1970). Corrections, too, is a field which recognizes a need for teamwork (Boslow, 1964; Conrad, 1964; Heim, 1966; Hogan & Campbell, 1968; Studt, 1959; Thomas, 1964). The introduction of therapeutically-oriented interprofessional teams into authoritative settings concerned with inmate control poses theoretical problems for the functioning of a correctional team.

Interprofessional teams have been utilized in school settings (Anderson, 1974; Brown, 1969; Christopholos, 1970; Grill & Himmelman, 1959) and in early child development programs (Neubauer & Steinert, 1950). The interprofessional team model has been proposed for health planning (Suchman, 1963) and for relatively new fields such as urban planning and locality development (Smith, 1971). Social work scholars have been involved in interprofessional research teams (Kaplan, 1960); like the clinical teams, the research teams are predicated on the belief that each discipline possesses part of the knowledge necessary for adequate formulation and solution of social science problems. Also like the clinical team, the interprofessional research team is prone to conflict and poor communication (Eaton, 1951; Luski, 1958).

This catalogue of settings highlights the ubiquity of the interprofessional team and the wide range of social work involvement in team practice. Seemingly the team is an accompaniment to the increased specialization of our age. The entrenched nature of the modality might lead one to believe that team delivery of services is well-formulated and tested. Yet the contrary seems to be true. Teams are established with few guidelines other than an effort to assemble representatives of the requisite professions. Professionals of different disciplines are then expected to collaborate in delivering effective service although they may have had no training or practice in the art and skill of team membership in their respective professional schools.

Even a cursory review of literature describing professionals on teams reveals friction, incongruent role expectations, poor communication, and omnipresent status concerns which, at times, would seem to subvert the original purpose of the team's existence (Banta & Fox, 1972; Rushing, 1964; Wise, Beckhard, Rubin & Kyte, 1974; Zander, Cohen, & Stotland, 1957). The essence of professional identity includes specialized knowledge, a protected area of function, and a system of professional values (McGlothlin, 1964; Pavalko, 1971). In view of the problems of interprofessional teams, it is possible that professional allegiances as now developed in professional schools and professional associations are not conducive to producing effective teamworkers.

Perhaps the interprofessional team formula is an inadequate concept for guiding action. The metaphor of a "team" masks the range and complexity possible in interdisciplinary interaction and cooperation. It avoids elaboration of the elements of effective teamwork. Although no generally accepted framework or typology of

teamwork has been developed, it is clear that many kinds of teams exist in practice, varying along dimensions such as purpose, composition, leadership patterns, intensity of interaction, duration of effort, and decision-making participation of members. The team is a complicated structure involving many interrelated variables, and little is known about the conditions under which the team functions effectively.

### DEFINITIONS OF THE INTERPROFESSIONAL TEAM

Ideally, a definition should offer guidelines to distinguish the defined entity from other similar phenomena. A useful definition, therefore, often lists a few essential characterizing attributes. Since the essential characterizing attributes of the interprofessional team have not yet been determined, definitions of the phrase vary. An effort to understand the concepts of teamwork might well begin with an examination of some of the proposed definitions and a search for commonalities among them.

An early definition was advanced by Luszki (1958) in a monograph on interdisciplinary research teams:

An interdisciplinary team is a group of persons who are trained in the use of different tools and concepts, among whom there is an organized division of labor around a common problem, with each member using his own tools, with continuous intercommunication and reexamination of postulates in terms of the limitations provided by the work of other members, and often with group responsibility for the final product [p. 10].

For Luszki, then, the essential ingredients of the team included diverse training, tools and concepts of the members, a common problem, a division of labor, and continuous communication and evaluation. Group responsibility for the outcome of the project was seen as a frequent but not as a necessary condition.

Although this classic definition pertained to scientific research teams rather than professional practice, it has been modified for the interprofessional team and has recently been utilized by several social work authors (Briggs & Van Voorst, 1974; Powers 1973). The latter worded the definition as follows:

An interprofessional team is a small, organized group of persons, each trained in different professional disciplines and possessing unique skills and orientations, among whom there is an organized division of labor, around a common problem, with each member contributing his own talents, with continuous intercommunication, reexamination and evaluation of individual efforts in terms of the limitations provided by team goals and objectives, and with group responsibility for the final outcome [p. 2].

The above definition has been quoted in full because it raises many of the issues pertinent to team processes.

Powers' formulation is, of course, cast in ideal terms; it is not likely that many teams meet its stringent assumptions for continuous intercommunication and reexamination, team goals and objectives, and organized division of labor. The definition also contains some debatable points. For example, the skills and

orientations of each profession are required to be "unique" and group responsibility for final outcome has become integral to the definition. Finally, a few variations on Luszki's original wording might be noted. The word "small" is included, suggesting that there is some size beyond which an interprofessional team cannot function effectively. Also, it is emphasized that each profession possesses a differing "orientation" as well as group of skills. The varying philosophical and ethical perspectives of the professions create both strength and problems for team functioning. The use of the term "orientation" reminds one that the professions equip their members with values as well as ideas and skills.

Konopka (1959) emphasizes cooperation and competence as essential aspects of teamwork:

Teamwork in professional undertaking demands high competence of each individual team member as well as the capacity to use this competence in a joint undertaking for the benefit of a common goal [p. 107].

Addressing the subject of teamwork in the health field, Bartlett (1961) proffers a definition. Teamwork, in her formulation, is:

... the organized, continuous, coordinated activity of a small group of individuals from two or more of the health professions working together under the auspices of a single agency to further common objectives such as patient care or program development [p. 226].

Again common objectives, differing professional skills, and coordination of activities are included. Bartlett also alludes to size as a factor and then adds a structural dimension concerning the administrative auspices of the team. Referring specifically to teamwork between physician and social worker, Krakow (1964) defines the term as a process involving "joint thinking and planning by the social worker and the doctor on the patient's behalf." This definition precludes the kind of teamwork which merely involves one profession carrying out the directives of another. Aradine (1973) discusses collaboration between the physician and the nurse, a relationship which in the past has often been perceived by both parties as hierarchical, in a way which emphasizes joint problem solving:

Collaboration implies a process of working together, with shared goals and philosophy and understanding of the professional and individual skills, knowledge, and characteristics of one's self and one's partner. It requires the willingness and maturity to share, to adapt, to listen, to communicate directly and openly about one's feelings, thoughts, and differences, and to be sensitive and responsive to one another's expectations. Collaboration must include a system and processes which provide for feedback and for convergence toward goals through joint problem solving [p. 656].

The definition above suggests that a high level of interpersonal skill is necessary for the participants in genuine collaboration.

An interesting definition proffered by clinical pharmacists (Cain & Kahn, 1971) states that teamwork is "work done by a number of associates, all subordinating

professional prominence to the efficiency of the whole [p. 2224].” Here the definition attempts to delineate the relationship between the team and the profession as competing reference groups and suggests that the team should take precedence.

Beckhard, a critic of teams from his perspective of organizational consultant and management analyst (1972), offers a simple definition: “A team is a group with a specific task, or tasks, the accomplishment of which requires interdependent and collaborative efforts of its members [p. 292].” Not only is interdependence stressed, but this definition stipulates that the team must actually require the contribution of all its member professions.

Several authors include a concept of democracy in their very definitions of teamwork. Whitehouse (1957) provides an early example of this emphasis:

Teamwork . . . is a close, cooperative, democratic, multi-professional union devoted to a common purpose—the best treatment for the fundamental need of the individual [p. 49].

This notion of democracy, although rarely well-specified, recurs in definitions of teamwork. Such formulations raise more questions than they answer because of the ambiguity of emotionally-laden words like “democratic,” as well as the legal responsibilities borne by various professions on the team. It is nevertheless important to decide whether a process dimension such as democracy—operationally defined—is indispensable to the definition of interprofessional teamwork, or whether several styles of leadership and participation are possible for the team group.

Taking the cited definitions together, common elements are identifiable. All definitions allude to common purpose, separate skills or professional contributions, and some process of communication, coordination, cooperation, or joint thinking. The varying emphases of the different definitions reflect the biases of the authors about how an interprofessional team should function. For the purposes of the present work the three elements of a common objective, differential professional contributions, and a system of communication will be considered necessary for an interprofessional team to exist.

### **RATIONALE FOR INTERPROFESSIONAL TEAMWORK**

In several fields of practice, including health care, rehabilitation, mental health, penology, and even education, interprofessional teamwork is almost taken for granted as an ideal approach to services. Although the interprofessional team has not lacked critics, there has been little serious search for alternative modes of organization, and very little effort to evaluate the effectiveness of interprofessional team work in comparison with other forms of delivery. An analogy might be made to the family, an institution which has been widely criticized for failure to fulfill its societal purposes. Many plans have been suggested for improvement of family processes, but only a few iconoclasts have suggested that the family be abolished. Similarly, the interprofessional team, with its obvious imperfections, is an easy target, yet it is generally agreed to be the major vehicle for serving society in this complex technological era.

Recently, however, serious suggestions have been made that the interprofessional team is becoming dysfunctional, especially as professions subdivide and proliferate. Some criticism of the interprofessional team is really an indictment of professions themselves and the role they play in society. The rest of the chapter marshals some of the arguments for and against interprofessional teamwork which are found in professional literature. Although roughly equal lists of advantages and disadvantages may be drawn up, the literature contains many more enthusiastic endorsements of the team than it does negative comments.

### **Arguments for Interprofessional Teamwork**

Professional jurisdictions, it is often pointed out, are rather arbitrary and do not reflect the divisions of human problems. Alluding to the need for multidisciplinary research teams, the Sheriffs (1969) state: "... man does not arrange his problems or divide them neatly along lines laid down by academic disciplines [p. 71]." The observation that humans have multiple problems with multiple causation, and that both problems and causes cross traditional disciplinary lines, is even more pertinent to the interprofessional practice team than to the scientific research team. It is well known that the man with a health problem may also have an economic problem, a legal problem, or a social problem, and that very likely his problems are interrelated. Advocates of team services feel that professionals with the requisite skills should be organized in teams to provide clientele with more effective and efficient service. As one writer (LeBaron, 1967) stated, the lines which separate the professional specialties are "not present within the real situations with which the specialist deals [p. 500]."

Many believe that the interprofessional team is able to deal with more complex problems than could professions working singly. The interprofessional team can apply a wider range of appropriate skills. The several professions are each acutely aware of the knowledge explosion and the growing impossibility of remaining skilled and up-to-date in a wide range of areas. While the need for specialization is thus recognized, the interdependence of systems is also acknowledged. "Systems theory," to professions interested in serving the whole man, suggests a need for interprofessional cooperation.

Conceivably, of course, a wide range of professional services could be delivered through a network of referrals rather than an interprofessional team. Such a process would be cumbersome, however, with attendant duplication and annoyance to the clients. Accumulation of services under a single roof is more likely to satisfy the consumer and also to control the process of client attrition before complete service is provided. Furthermore, professionals who do not work together on teams may be insufficiently informed about each other's skills to make the appropriate referral suggestions. Advocating teamwork between public health nurses and social workers, Kaufman and Shapiro (1962) argue convincingly that in the absence of the interprofessional team, the burden for synthesis of services falls unfairly upon the patient rather than the deliverers of care.

A related advantage of the interprofessional team can be described in economic terms. It has been suggested (Horwitz, 1970) that the team arrangement allows each

professional to spend a maximum amount of time performing his most specialized and advanced skills. This should lead to better service as well as higher satisfaction for team members.

Another benefit of the team accrues to many of its member professions, as a profession, although it might also be construed as an enhancement of service; this is the advantage which less established professions receive when their skills are recognized and incorporated on the team. Writing in their own professional journals for an audience of professional colleagues, members of these professions are frank about the importance of team membership as a point-of-entry to reach potential recipients and to publicize their skills. Clinical pharmacists aspiring to be part of the medical team (Cain & Kahn, 1971) or home economists who envisage themselves on the public health team (LeBaron, 1967) discuss strategies to establish a place for their profession. Social work literature, too, expresses this theme, especially in regard to fields where social work is a relative newcomer. In such instances part of the rationale for teamwork is the opportunity for a professional group to begin delivering the services it considers important and to inform both other professions and the public of its contribution.

Proponents of the interprofessional team also find it an ideal vehicle for preventive services. While the need for the direct services of some team members may be indicated, others may offer direct or consultative services aimed at preventing or minimizing future problems. For this reason the public schools, institutions with the direct purpose of education, may add mental health personnel to the team, while health agencies may add educators, whose purpose is not to treat existing illness but to teach patients and the general public about health. In both these examples, the less traditional personnel are gaining entry to a clientele in order to serve a preventive function.

Some writers have emphasized the satisfactions that team members derive from interaction with members of other professional disciplines. Participation on a team can be an enriching and stimulating educational experience; generally, it permits the member to acquire some of the learning and skills of the other participating professions.

Finally, another advantage is what Powers (1973) terms the "shared guilt" phenomenon; it is reassuring to believe that errors may be reduced through interprofessional decision-making. Similarly, team support and validation of momentous and irreversible decisions, such as removal of a child from home, is described as an advantage of the intraprofessional social work team (Brieland, Briggs & Leuenberger, 1973).

### **Arguments Against Interprofessional Teamwork**

Some who suggest that the interprofessional team is not a desirable model for service delivery do so on the grounds that professionalism itself creates more obstacles to services than it provides benefits (Blum, Wahl, Lemon, Jornlin, & Kent, 1968; Friedson, 1970). Others object to the way the team concept has expanded into a large cumbersome mechanism advocated for almost all purposes (Ellwood, 1968; Halberstam, 1974).

Editorializing in a recent journal, Rae-Grant and Marcuse (1968) discuss the "hazards of teamwork" in the sense that individual responsibility for a patient may be abrogated. Under the teamwork model, it is possible that nobody accepts the challenge and responsibility for the patient's well-being. Arguing from an authoritarian physician's view, Halberstam (1974) makes a similar point; not only is responsibility diffused, but the patient receives conflicting messages from team members at a time of illness when, the author believes, ambiguity is less tolerable. Halberstam seems to be urging selective teamwork at the prescription of the physician. He points out that calling in a team to handle all aspects of medical care is like "the use of a howitzer to wipe out gnats [p. 169]." Although team medicine is appropriate for multiproblem families and for some complex disabilities, its general use is a fad to be deplored.

Ellwood (1968) raises profound doubts about the viability of the rehabilitation team in its present burgeoning state. Citing the fact that at least eight professions, including medicine, nursing, psychology, physical therapy, occupational therapy, social work, vocational counseling, and speech therapy now participate on the rehabilitation team, he questions whether the communication difficulties that ensue are not a serious disservice to patients. He lists the waste of space and time, the logistical problems of scheduling, the maintenance of separate record systems and physical domains, and the "elaborate and ceremonious codes of professional etiquette that the professions observe so punctiliously [p. 22]" as impediments to service. The patient, he suggests, is often caught in the middle of the struggles of the various professionals to communicate. Dr. Ellwood advocates that research be conducted into ways of reducing the number of professions involved in rehabilitation.

A related question worthy of serious research is the cherished concept of the one-to-one relationship. Opponents of the team idea state that the client or patient cannot form a positive relationship with a team, but must form it with one or more individuals. Although there is more speculation than fact on this issue, some authorities (Barker & Briggs, 1968; Silver & Stiber, 1957) suggest that the importance of the one-to-one relationship is exaggerated.

Eiduson (1964) suggests that the orthopsychiatry team has become inbred. In her view the roles of the members of the child guidance team are no longer distinct or viable. As disciplines have come to think alike and duplicate each other's skills, a conservatism has set in along with an emphasis on the personal and a self-consciousness on the part of members.

Many have commented on the rigidities and resistances to change characteristic of the professionals protecting their turf (Berlin, 1969, Pluckham, 1972). Some have even suggested that professional roles in fields such as mental health are irrational (Bay & Bay, 1973):

Each student of medicine, nursing, clinical psychology, etc. should complete his or her training as a *health worker* instead of being assigned titles like 'doctor' or 'nurse' which indicate places in one of the least justifiable pecking orders in our hierarchy-ridden society [p. 58, italics in original].

Elimination of professional identities clearly obviates the need for interprofessional teams.

Perhaps Blum is the most vociferous critic of the professions. He would replace many of our present professions with his multipurpose worker who would be capable of acting as a social worker, public health nurse, vocational counselor, and probation officer combined in one consistent neighborhood-based figure. He has been funded to try this experiment (Blum, *et. al.*, 1968) in which the multipurpose worker, called a primary counselor, (PC) may seek advice from other counselors with different backgrounds but never relinquish a case to anybody else. Justifying this approach, Blum writes bitterly of professional credentials:

Merit badges have become the elegant substitute for standards. Do you have your MPH? Apparently this has been much more reassuring than seeing what happened to the last twenty clients you served. To overcome this ostrich frame of mind which is more concerned with the plumes flying than with the sand in the visual apparatus, we are going to unfreeze the list of duties each skill may perform or the merit badge each worker must show [p. 467].

Friedson (1970), a medical sociologist, believes that the team is a myth in the health field. In his view, a team is impossible since the medical profession holds a dominant position. In the health field all professions, except dentistry, depend on the authority of the medical profession, and only medicine and dentistry are autonomous with respect to those outside their profession. Friedson presents the argument that professionally sponsored services have many of the drawbacks of bureaucracy, including red tape, cumbersome procedures, and impersonality. Yet because of the dominance of the medical profession, none of the safeguards of a bureaucracy exist. According to Friedson, the client's interests are lost in a service system organized along professional lines.

Others who do not go as far as Blum or Friedson in decrying professionalism suggest that the team of the future should not be defined along the lines of unique professional contributions, but should be conceptualized in such a way that deliberate role-blurring is encouraged (Frank, 1962; Sabshin, 1966). In this formula, professional jealousies over function are to be replaced by comfortable task-sharing and minimizing of professional boundaries in the interest of the client. Community mental health teams particularly (Oviatt, 1964; Topf & Byers, 1969) have advocated this focus. While the role-blurring focus is not entirely antagonistic to the inter-professional team, it does raise questions about a process which first calls for training professionals a particular way and then teaching them to blur the roles they have learned.

A possible disadvantage of the interprofessional team, and one which the role-blurring therapeutic milieu strives to avoid, is an elitism in regard to paraprofessionals who also serve the clientele. Many paraprofessionals, especially attendants, aides, and custodians in institutions, have frequent, direct contact with clients to an even greater degree than do the professionals. An interprofessional team which isolates paraprofessionals from communication is considered dysfunctional by many critics. Thomas (1964) has severely criticized the interprofessional

team in prisons because such teams have often excluded the custodial personnel. Interprofessional teams can, of course, be expanded to include non-professionals, yet status differences then do cause difficulties for team process. One such mental health team (Philippus, 1971) resorted to the strategy of referring to the professionals as "senior staff members" so as to avoid the term "paraprofessional," yet such a device almost seems to emphasize rather than hide inequities.

Finally, just as some individual professionals find that team practice is rewarding and gratifying, others are likely to find it unattractive. Among the disadvantages which may fall to the professional on the team are isolation from one's own profession, need to accept supervision and evaluation from a member of another profession, and, perhaps most importantly, lack of a promotion ladder within the team. Many interprofessional team positions seem to be dead-end in nature with advancement possible only by a move to an administrative position (Horwitz, 1970).

### **Incentives and Disincentives**

Thus far, the discussion has treated the advantages and disadvantages of teamwork as though they were the same for all professions. Yet the incentives for participation in team practice clearly are different for those established professions who may be giving up some area of function or some autonomy than for those aspiring professions who need access to clientele or the sanction of an accepted profession in order to deliver their services at all.

The advantages of team practice to the lower-status or less established professions are fairly evident. By team participation, members of that profession gain entry to clients with problems, receive the sanction of the trusted, older profession (often medicine or law) which reassures consumers, and have an opportunity to demonstrate and publicize their skills. Little can be lost and much gained.

What, then, are the incentives for an entrenched profession to begin working with members of other disciplines? Those who advocate teamwork often make the mistake of describing the advantages from the perspective of newer professions who attest to the ways that the addition of their services will improve the total program. But the physician or psychiatrist contemplating teamwork is considering the addition of more personnel who will make the administrative apparatus more cumbersome, increase costs and overhead, and perhaps rob him of part of his function. If tasks are not being reassigned, then the new professional will be offering a service not previously considered necessary which the established professional must justify and accept.

There are at least two advantages for the higher-status professional in interprofessional teamwork. The first is the benefit he may recognize if he sincerely believes that the client requires the services of other professionals in order to profit by his own. For example, the physician who believes that anxiety is correlated with exacerbations of a particular illness is more likely to accept a social worker rendering service to the patient with the problem. In such a case, the social worker is perceived as offering a service which complements and enables his own service.

Similarly, a lawyer may recognize that a disorganized and impulsive client may be more likely to observe the restraints necessary for him to win the case, or be more likely to appear in court at the appropriate time if that client is assigned a social worker.

The established profession might also discern an advantage in relinquishing unrewarding work to members of other professions. An example of this would be the physician who is pleased to have the social worker see the hypochondriacal patient who shows no sign of organic illness. In fee-charging agencies or agencies which generate revenue through third-party payments, it may even be shown that the addition of other personnel to perform such tasks decrease the overall costs of the operation. For example, law firms employing marriage counselors to help a couple decide if they really want divorce have saved money even after paying the counselor's salary.

It would seem useful for the various professions, however entrenched or tenuous their hold in a given service area, to ask themselves what advantages are inherent in teamwork for those professions whom they wish to involve in collaboration. It is incumbent on the proponents of interprofessional teamwork to persuade those who are less enthusiastic. If advocates of the team can convince another professional that the addition of their services can help the latter perform his own job either better or more pleasantly, he will probably win his point. The question must be explored as to what each profession gains and gives up in the arrangement, and the balance must not be all in favor of the profession requesting entry.

Table 1 summarizes the advantages and disadvantages of the team approach as suggested in this chapter, citing the various arguments that have appeared in the literature. Rather arbitrarily, the list is divided into the client's perspective and the profession's perspective; the distinction is by no means as clear as the columns would indicate, however, and it would be supposed that the quality of client service might be affected by factors which add to or subtract from the satisfaction of the professionals who offer them. One might note that the arguments against teamwork tend to concentrate on characteristics of the malfunctioning team unit.

*Table 1*  
*Rationale For and Against Interprofessional Teamwork in Literature*

Rationale for	Rationale against
<i>For client:</i>	<i>For client:</i>
– coordinated service	– narrow, rigid professionalism deters service
– skilled service	– team may interfere with one-to-one relationships
– duplication avoided	– client caught in team miscommunication
– interdependent problems can be managed	– too many professions diffuse responsibility for client
– “systems approach” to problems	– team protocol elaborate and time-consuming
– additional insights possible	– professionals on teams may become inbred, self-preoccupied and conservative
– convenience	– paraprofessionals may be or feel excluded from interprofessional team
– client does not have burden of integrating services	
– preventive services can be introduced along with direct services	
<i>For profession:</i>	<i>For profession:</i>
– access to other professions simplified	– a team is not possible if any profession is dominant; others are alienated
– communication among professions is enhanced	– deliberate role-blurring on teams may make professionals anxious about weakening profession
– learning promoted	– team members may be evaluated by those outside profession
– professionals can practice best skills most of the time	– isolation from colleagues; less professional stimulation
– less established professions gain entry to clientele	– often no promotion lines within a team
– “shared guilt” phenomenon	– some established professions may have too much to give up and too little to gain
– other professions can facilitate work of one’s own	

## *Chapter II*

### **PROFESSIONALS AND THEIR BEHAVIOR ON TEAMS**

The proliferation of professions in modern society has interested sociologists for some time. According to McGlothlin (1964), the professions are an outgrowth of society's need for special services. The purposes of a profession are to:

- (1) unite competent people to do socially significant work of increasing usefulness, (2) advance knowledge through research, and (3) protect members from unwarranted attack, unethical practice, encroachment, or quackery [p. 11].

The professions have traditionally controlled quality and quantity in their respective fields; in so doing, they have developed the protectionistic guild-like features which some authors (Friedson, 1970) cite as evidence that professions serve themselves rather than their clientele.

The term "profession" is employed somewhat loosely. Presently the imprecision is exacerbated by the fact that many occupations aspire to professional status. Pavalko (1971) struggled with the distinction between occupation and profession and arrived at a continuum approach. In his scheme professions are characterized by attributes such as mastery of knowledge, relevance to basic societal values, a training period which is lengthy, specialized, abstract, and value-oriented, a service motivation, autonomy, and commitment to a life-long pursuit. Clearly most occupations that are considered professions would not qualify on all of these factors, yet each profession or would-be profession may be examined on the extent to which the criteria have been achieved. While some of these criteria, most notably a service motivation and a specialized body of knowledge should be conducive to interprofessional teamwork, other criteria such as autonomy and a strong orientation towards a value system may be detrimental to collaboration.

Wilensky (1964) classified professions into four groupings, including (1) established professions, such as law and medicine, (2) marginal professions, or professions in process, such as nursing, (3) new professions, such as hospital administration or engineering, and (4) doubtful professions such as morticians. In this formula, social work was placed in the second category of professions which are marginal and striving for recognition. In the same vein, social work has sometimes been called a semi-profession (Etzioni, 1969; Toren, 1972) along with nursing and teaching; semi-professions are characterized by less than complete autonomy since their members tend to work in bureaucracies where they are subject to authority of those outside the profession.

The place of an occupation on the hierarchical scale of professions must have some significance for the interprofessional team. Surely a semi-profession, or a profession attempting to establish itself in the eyes of colleagues and the public will show considerable concern for its professional identity. Some acts of team members may be designed to protect and solidify that identity as much as to further the substantive work of the team. But the established professions also act to safeguard professional status as new disciplines emerge and carve out functions in territory that was formerly theirs alone. It has been pointed out that a few decades ago the doctor and nurse only were present in the hospital, joined by the dentist and the pharmacist in the community; now these four original health professions are augmented by a score of others. A task force on collaboration in the health field (Continuing Education, 1966) concluded:

It would be difficult to say whether the role concept of the old prestigious profession or that of the newly emerging profession is more of a hindrance to interaction. To protect your share in the sun may cause strong professionalism to show; to fight for your share in the sun may cause strong professionalism to develop [p. 24].

Wilensky and Lebeaux (1958) emphasize that a profession must be able to claim "exclusive competence in a specified area [p. 284]." They go on to suggest that social work, in common with other professions in the human relations field, has "only tenuous claim" to such exclusivity. Briggs (1973) suggests that social work is caught in a struggle for "functional specificity;" currently there is no function which is legally reserved for the social worker in society. In addition, the difficulties experienced by the profession in staking exclusive claims are compounded because social work deals with problems of everyday living in which most laymen believe they enjoy some expertise.

Social work, too, differs from some other human services in the broadness of its scope; the profession has spread into many fields of practice and utilizes an enormous range of methodology. Professional social workers at extreme ends of the profession seem scarcely acquainted with each other's expertise. In a plea to social work to define and narrow its scope, Levy (1974) suggests that the profession's proper focus is to help clients manage themselves in relation to their social environment. Social work goals, he argues, are not synonymous with the goals of the host setting which could include improvement of physical or mental health, deterrence of crime, or facilitating learning. These views are compatible with the recent work of social work theorists who have attempted to specify the common elements of social work practice. Bartlett (1970) suggested that social work knowledge and philosophy is centered around a concept of social functioning—that is, persons coping with their environments—and that a wide range of interventive techniques cluster around this central purpose. Such innovative efforts have made strides in unifying the several wings of the social work profession, but the issue of the search for exclusive competence remains. Although the interests, values and skills of social work are combined in a unique constellation, it would be impossible to claim exclusive title to any particular technique or idea.

## Role Overlap among Professionals

Although some definitions of a profession include an area of exclusive competence, it is clear that overlapping interests and skills exist among collaborating professions. In comprehensive mental health centers, considerable duplication of function occurs and is encouraged among psychiatrist, psychologist, social worker, and psychiatric nurse (Topf & Byers, 1969). Another common example of overlap exists between functions of the public health nurse and the social worker; this overlap has been suggested as a reason for conflict between the two groups (Buchan, 1971).

Almost twenty years ago, a clergyman (Hiltner, 1957) discussed the issue of overlap among helping professions, developing a concept of the "village green" or region of common interest legitimately shared among professions. Much conflict, he suggested, stems from disagreement about the extent of the village green. This no-man's land generates tensions which are sometimes relieved by destructive and artificial compartmentalization of roles. Another way of reducing tension and providing an ultimately harmful kind of support is the practice of subsuming another profession into one's own. Hiltner offers the example of the psychiatrist who commends the clergyman on being a "wonderful psychotherapist." Here the supportiveness is ultimately unhelpful because it suggests that the clergyman gets good results despite rather than because of his professional affiliation.

Hiltner, then, seems to urge that professionals strive to function creatively within an overlapping situation, learning to tolerate the accompanying anxiety. The opposite tendency has been more often described in practice. Pluckham (1972) discusses "professional territoriality," a phenomenon which she believes is endemic in modern society. Professional territoriality is characterized by a zealous guarding of function on the part of professions which extends to the use of space, equipment, tests or procedures, and, most absurdly, even to the use of certain language.

Semantic differences between professionals sometimes do reflect underlying philosophical differences which impede work together. Horwitz (1970) refers to the differing "criteria of credibility" which professions employ to determine which facts are significant and important. In an effort to clarify sources of misunderstanding between professionals in the learning disability field, Christopholos (1970) differentiated the amount of "pre-treatment specificity" needed by the physician, the psychologist, and the educator. According to his formula, the physician requires detailed history of past symptomatology, the psychologist is oriented towards present behavior, and the educator must plan in terms of specific objectives for the future. The author suggests that these distinct orientations should be maintained and recognized in order to reduce competition and clarify roles. He proposes a "multi-disciplinary paradigm" in which:

... causal terminology should have a medical emphasis, current symptomatic descriptions should have a behavioral, psychometric emphasis, and objectives of treatment should be stated in terms of achievement of specific educational curricula [p. 168].

Such a compromise is designed to integrate the orientations of the disciplines involved.

Taking a somewhat different tact to the same problem, Bahn (1971) reports the work of a task force to develop a classification system for the use of child guidance personnel when describing psychosocial functioning. The work was to culminate in a set of forms whereby all professions involved might use the same language to describe familial-socio-demographic data, another set of forms to describe the client depending on his/her age, and finally, a detailed but standardized set of forms for the use of each particular profession on the team. The mistrust among the professions was so great that many expressed unwillingness to employ a form which would enable teammates to understand and perhaps misuse the information. Somewhat plaintively the author asks:

Can a standard core profile be developed as a beginning description of the individual, with terms understood by all appropriate professionals? If not, is there really any purpose to the interdisciplinary approach of our community agencies today [p. 836]?

The protectiveness of professions and the sense of territoriality in the face of genuine but at times unacknowledged common areas of interest produces difficulties for the professional working in a setting where no traditions for his profession yet exist. Nursing, as a core profession in community mental health, has faced this problem. Stuecks (1965) suggests that in such a novel situation, the nurse must assume that nobody on the team understands anything about the nursing role. When first invited to collaborate, the nurse must analyze the need for nursing services in the light of existing problems and existing programs. If she discovers no clear-cut role for the nurse, she should decline to participate, thus "paving the way for a more appropriate discipline to accept services [p. 318]." This view is predicated on the assumption that there should be a unique role for each professional on the team.

Summarizing the foregoing discussion, interprofessional teamworkers seem to be ambivalent about defining their roles. There is a continuous interplay between the ideal of a professional responsibility to establish and maintain a unique and specific position for one's own profession on the team and the professional responsibility to work with others, tolerating ambiguity and overlap in order to reach a new synthesis of services.

### **PROFESSIONAL AUTONOMY AND THE INTERPROFESSIONAL TEAM**

One of the strengths of the interprofessional team, at least in theory, is its ability to bring to the task the varying perspectives and orientations derived from the several professions involved. As was stated earlier, a profession, by definition, possesses a body of knowledge, a frame of reference, and a value system. By most definitions, too, a profession aspires to autonomy from control which emanates from outside the profession. The profession itself serves as a major reference group for its members; it is the yardstick by which they evaluate their job performance.

If loyalties to team goals conflict with mandates of professional behavior, a

collision course is inevitable. In such cases, the team member must make a difficult choice, at times involving the ethical foundation of his profession. Horwitz (1970) suggests that the professional serving on an interprofessional team may be driven, by his very isolation, to be even more influenced by the professional reference group than when he is comfortably surrounded by his confreres.

Professions differ in how much guidance and direction they will accept from other professions. There is some evidence, for example, that social workers perceive psychiatrists as a relevant reference group (Rushing, 1964; Zander, Stotland & Cohen, 1957) and that nurses view physicians as one of their reference groups (Rushing, 1964). On the other hand, there is evidence that social workers and learning disability specialists are not willing to accept direction from the school psychologist even though the latter feels comfortable in the decision-making role (Hyman, Duffey, Manni & Winikur, 1973). A physician, in another example, may consider that other team members are "paraprofessionals" whose task is to fulfill his orders, whereas they may perceive his referral as merely a suggestive starting point for their own independent evaluation and action.

It is also likely that there are phases in the willingness of a profession to fill a handmaiden role to another professional group. Historically, as the nursing profession has become more self-conscious in its struggle for autonomy, nurses have withdrawn from interprofessional collaboration, making their own nursing assessments and plans in isolation from teammates (Woolley, Warnick, Kane & Dyer, 1974). This, of course, is a sterile kind of autonomy, won at the expense of real significance to team activity, yet it seems to be a stage in the development of a profession. Social workers, too, have gone through a period when they entrusted their deliberations to social work supervisors and a record unshared by other professions, rather than venturing with their ideas into the open market of team debate. Both nursing (Aradine & Pridham, 1973) and social work (Watt, 1973) are emerging from this period with an interest in teamwork on a new, more equal basis in which their professions share in problem-solving.

Anyone who has ever served on a committee is aware that group activity calls for some compromise of individual preference in order to permit the group to function. Such compromise is also true of the interprofessional team, but since each member represents a professional discipline, it is professional autonomy as well as individual autonomy which may be sacrificed. This is a theme which is seldom explored explicitly on the teams but which may underlie the conflicts which flare up periodically.

While some compromise of professional autonomy is essential to team practice, at times the sacrifice demanded of a given profession may be very great. Social workers are especially vulnerable to extra-professional regulation:

The contention that only his peers assess the expert is perhaps nowhere more commonly disproved than in the case of the social worker in interdisciplinary team practice. The decision to hire, the evaluation of ongoing service processes, and the power to promote or terminate are all likely to be in the hands of an individual with no professional qualifications in social work [Horwitz, 1970, p. 122].

Quite possibly an ideological commitment to an interprofessional field of practice counters the unpleasantness inherent in loss of autonomy. Fields such as rehabilitation and community mental health are characterized by their distinct ideals such as "treatment of the whole person" or "return to the community." The community mental health ideology has been recognized to the extent that a scale has been developed to identify those individuals whose outlook might make them compatible community mental health employees (Baker & Schulberg, 1967). Other fields such as gerontology or early childhood education have similar potential for a belief system to develop around service to the elderly or the very young in our society. In prisons, on the other hand, interprofessional teamwork has sometimes floundered because of conflicting ideologies directed partly towards rehabilitation and treatment, but partly towards control and deterrence (Conrad, 1974; Kelling, 1968). Perhaps eventually a new profession is created from an interprofessional field with a strong ideological component, making the team idea less meaningful. Public health is an example of an interprofessional field which may have come to be considered a profession in itself. In such cases the interdisciplinary field, as well as the profession, becomes a reference group to the practitioner, and the struggle for professional autonomy is lessened.

### **The Social Worker on the Interprofessional Team**

The themes of the preceding discussion can be illustrated with the example of how a particular profession has experienced interprofessional teamwork. Each profession has its own history, interests, and concerns which effect its interaction with the team. Occupational therapy, for example, was born during World War II and, from the beginning has been regulated by members of the medical profession as well as by its peers; occupational therapists depend on physicians for licensure and right to practice (Pavalko, 1971). The professional struggle of pharmacists also has its distinctive nuance; pharmacists on the team struggle with the entrepreneurial label of the small shopkeeper which colors the layman's view of that profession and strive for an opportunity to utilize the full range of their knowledge about drugs and drug reactions. Examples could be multiplied, but the point is evident that each professional should at least understand the concerns that his own profession brings to interprofessional contexts, and perhaps should also try to understand the particular strivings and status issues which effect the professionals with whom he works most.

The challenge to the social work profession in forging a role on the team is magnified because so many professions have boundaries which overlap those of social work. The psychologist, the psychiatrist, and more recently, the psychiatric nurse have therapeutic functions very similar to that of the social worker in many settings. The occupational therapist, the recreational therapist, and now the industrial therapist overlap with the social group worker in particular. The public health nurse, the health educator, and even the home economist claim roles that in some ways duplicate the expertise of the social worker. Clergymen, rehabilitation counselors, guidance counselors, school teachers and school psychologists, planners and administrators at various times have collided with social work territory. Many

professions are gaining psychological insights and adding a counseling role to their functions so that one now reads of "psychodietetics" (Manning, 1965) and "psychoreligious counseling" (Peterson, 1968). At the same time various professions are moving into the community; both nursing (De Young, 1968) and occupational therapy (Watanabe, 1967) have emphasized knowledge of community agencies as a particular expertise their professions bring to the team. Perhaps no profession as much as social work has so large a cast of collaborators with whom it needs working alliances.

Social work has a long history of team practice, and, as a profession, is quite committed to the team model. Since social workers are interested in helping clients obtain services and are engaged in mediating between client and resources in the community, they welcome the opportunity to ensure that appropriate services reach the clients. Nevertheless, the quality of the social work experience on the interprofessional team has been criticized by those within and outside of the profession.

Bartlett (1970) has noted that social workers emphasize the rights of their clients to self-determination and consistently act in a way designed to help clients help themselves. She notes that social workers have transferred these facilitative tendencies to their interaction with colleagues on teams to the detriment of their ability to make an effective contribution to the team process. Instead of asserting their opinions during team conferences, social workers have tended to be passive, indirect, and self-effacing to the distress of other professionals, such as physicians, who are accustomed to a more direct and vigorous approach.

Social workers have noted that they are not always recognized for their skills on the team (Phillips, *et al.*, 1971). Some have attempted to define their role more clearly. Smith (1973), a British social worker, who noted the lack of acceptance of her profession in hospitals in England, attempted to delineate three distinctive contributions of the medical social worker including (1) knowledge of the development of the human personality, (2) knowledge of sociological factors involved in attitudes towards illness and death, and (3) ability to combine the first two with a skill in forming relationships helpful to the patient. Via regular team meetings, she suggests, social workers can help other teammates articulate the feelings invoked in them by particular patients and their own fears in dealing with death.

Some social workers have attempted to bridge the gap between theirs and other professions with information. Chauncey Alexander (1972), executive director of the National Association of Social Workers, prepared an informative question-and-answer article in a nursing journal, addressing such issues as the nature of social work education, licensure, professional organization, salary scales, and so on in a factual way. In another nursing journal, Murdaugh (1968) attributes the friction sometimes existing between public health nurses and social workers to lack of clarity about each other's skills. Deploring the fact that no clear criteria existed to help the social worker or public health nurse know when to refer to each other, she devised a typology of family functioning to inform the nurse which kinds of families might profit by social work help. Demsch (1968) similarly provides guidelines for the school nurse to decide when to utilize the school social worker.

The communication between social workers and lawyers is known to be poor (Katz, 1961; Mueller & Murphy, 1965; Sloane, 1967). They differ in use of language, views of precedence, manner of gathering information, and even in their very definition of a case. It has been suggested that more productive teamwork might ensue if each profession refrained from judging prematurely the method and approach of the other. At the same time efforts have been made to interpret the social worker's characteristic diffuse focus to the lawyer and the lawyer's specificity and advocacy procedure to the social worker.

There is some suggestion in the literature that more friction exists between social work and public health nursing than most team collaborators. Paradoxically this has been ascribed both to the similarity between the two professions (Buchan, 1971) and to the distinctive differences (Banta & Fox, 1972). The latter describe a number of health teams in which the public health nurse showed an undifferentiated service-oriented attitude towards clients, whereas the social workers attempted to be detached and objective. The nurses interpreted the social workers as aloof and unfeeling, whereas the workers interpreted the nurses as unprofessional. That particular study reported that the nurses tended to originate from a lower-middle class background and the social workers from an upper-middle class background, and that personal rather than professional differences led the nurses to criticize the social workers' dress and mannerisms. Several other studies (Hayes, 1970; Robinson, 1967) suggest friction between these two disciplines, although there is no information on whether a class difference was also present.

Although social workers have been part of the health team since the turn of the century, they have for almost as long been on a defensive position on that team. Social work had no stronger advocate than Dr. Richard Cabot, who is credited with hiring the first social worker in a hospital. Yet he too pleaded with the profession to articulate its skills more clearly. In words that have a distressingly contemporary ring, Cabot wrote:

Even now I think that the value of the social worker and his proper recognition are considerably limited by the fact that he cannot recognize himself or tell you what the value of his profession is. He is an expert. *But in what is he an expert? What is his special field of knowledge or skill?* [Cabot, 1909, p. 38, italics in original].

Other more recent critics have been less kind. Banta and Fox (1972), reported that the social workers were a divisive influence on the teams since they depended heavily on their social work supervisors. Another source of contention was the social work view on confidentiality which led them to keep their records locked in their offices rather than shared with the team. Describing a team approach to health care in a low-income housing project, Silver (1974) criticized social workers because they displayed a preference for office practice over home visits. He also noted that the public health nurses seemed better accepted than the social workers by the patients, leading him to speculate whether it might not be wise to train public health nurses in additional social work skills. In planning the health teams at Martin Luther King Neighborhood Health Center in the Bronx, Wise (1974) admitted his

ambivalence towards social workers caused him to decide to utilize community persons trained in health information and advocacy skills as a substitute. "Instead of a social worker, I thought, why not train a community person to do many health related tasks [p. 10]?" The fact that many problems developed in incorporating these new "health workers" on the teams does not comfort the social worker for the fact that his skills were deemed replaceable by a paraprofessional with a smattering of training.

It is difficult for social workers not to react defensively to such sweeping criticisms. Usual responses include a retreat into professionalism and a more steadfast insistence that the status of the profession be recognized (Rushing, 1964). A more productive reaction would be a continuation and intensification of the effort to clarify, explain, and demonstrate the service to professional teammates. The status concerns of social workers are an understandable reaction to attacks on their professional worth, but the reaction then creates a vicious circle which prevents the worker from functioning with maximum flexibility and creativity.

This section has highlighted some of the negative reactions of interprofessional teamworkers to the social work presence. The fact that social workers have continued to be durable participants on a wide variety of teams attests to the fact that the profession has made a positive contribution. In understanding the experience of a particular profession, it seems more valuable to extract the criticisms than recite the praises offered by other disciplines. Some of the criticisms stem from professional standards which social workers value and have strived to maintain. Extra-team supervision has been part of the accreditation process of the profession. Confidentiality in handling patient's records has also been a carefully taught social work principle. It may be that some practices need to be reassessed in terms of the interprofessional team, but it also may be that some practices which are dysfunctional for teamwork are integral to a particular profession. It is likely that every profession maintains some activities or adheres to some values which somewhat impede the team process.

### **Research on Professional Roles**

Ideas about interprofessional interaction are partially derived from anecdotal impressions. An enormous volume of expert opinion is available, as well as exhortations that professional groups should learn to cooperate. Actual research which indicates how different professions perceive themselves and each other and their expectations of each other in a working situation is much sparser.

Twenty-seven articles were located which report research relevant to how professionals perceive each other and get along together. These findings are summarized in chronological order in Table 2, under the headings of professions considered, methods, and major findings. The studies do not examine single teams but rather compare professions as groups.

Fourteen of the studies compare a sample of members of one profession to a sample from at least one other discipline in order to better understand attitudes and expectations (Zander, *et. al.*, 1957; Olsen & Olsen, 1967; Robinson, 1967; Sloane, 1967; Peterson, 1968; Davis, 1969; Brollier, 1970; Hayes, 1970; Rehr, 1970; Smith,

1970; Brennan & Khinduka, 1971; Geertsma & Hastings, 1971; Hyman, *et al.*, 1973; Powers, 1973). Another group of eight studies (Oviatt, 1964; Rushing, 1964; Piliavin, 1965; Goldschmid & Domino, 1967; Sternback & Pincus, 1970; Banta & Fox, 1972; Randolph, 1974; Schrage, 1974) compare members of professions also but do so within the context of one or two institutions so that those polled are also persons who work together. Four of the studies (Style, 1965; Goldin, 1966; Stotsky, *et. al.*, 1968; Williams, 1970) poll members of one profession only but attempt to determine that profession's view of itself in relation to some other group. Finally, one study (Topf & Byer, 1969) examines the interrelationships of mental health professionals through a content analysis of literature. The studies vary greatly in size of sample, rigor of design, and instruments used but taken together they suggest some of the incompatibilities of role and sources of friction that might arise among professionals functioning on teams. Together they also include a wide range of fields that utilize interprofessional teams, namely, health, mental health, education, legal services, and corrections.

Two studies reviewed here (Piliavin, 1965; Sternback & Pincus, 1970) concern social workers and cottage parents, known in the studied institutions as "counselors." Although these latter individuals are not considered professionals by most definitions, they are perhaps members of an emerging profession. In any event, the studies were included both to provide an example from the correction field and to include some research depicting social work in relation to a group of lower status than itself.

No-effort is made here to recapitulate the findings, some of which may be read in the right-hand column of the table. Taken as a whole, the studies do indicate that there is little congruence between the way a profession defines its own role and the way others define it. This is especially true when a higher-status profession is delineating the role of a lower-status profession (Zander, *et al.*, 1957; Rushing, 1964; Rehr, 1970; Smith, 1970; Brennan & Khinduka, 1971; Power, 1973). Yet the support of the higher-status individual is often necessary for a lower-status profession to function satisfactorily; in Williams' study (1970) of school social workers, it was found that a satisfactory relationship between the social worker and the principal was the determining factor in whether the school was deemed conducive to social work practice.

Sometimes lack of knowledge of another professional's competence is documented. Teachers misunderstand the expertise of the school psychologist (Styles, 1965) and physicians are extremely uninformed about rehabilitation counseling (Stotsky, 1968). Sometimes, however, the difficulties are not a matter of ignorance but substantive disagreements. Goldschmid & Domino (1971), for example, report that various professions disagreed on the issue of identification of patients for whom psychotherapy might be indicated. Psychiatrists, psychologists, and social workers tended to select the anti-social, withdrawn, friendless individual, and attendants picked the violent, disruptive patients as their choices for treatment. Smith (1970) showed substantive disagreement between lawyers and social workers on the purpose of legal aid services and Sloane (1967) described disagreement between those two professions on the value of the advocacy system.

*Table 2*  
*Summary of Research on Role Relationships among Collaborating Professions*

Reference	Professions	Methods	Major Findings
Zander, et al., 1957	psychiatry, social work, psychology	160 interviews of these professionals in 6 cities	Subordinate status professionals are perceived as supportive when they do not threaten the security of the superior and as hindering when they do threaten the superior's security
Oviatt, 1964	psychology, psychiatry, social work, nursing, attendants	63 interviews with staff in role-blurring hospital	<ul style="list-style-type: none"> <li>—more than 75% felt their profession performed a unique function</li> <li>—all groups perceived psychiatrists as most powerful and attendant as least</li> </ul>
Rushing, 1964	psychology, social work, nursing, recreation therapy, psychiatry	observations and interviews of staff of mental hospital	<ul style="list-style-type: none"> <li>—social workers and psychiatrists disagree on social worker's role</li> <li>—unlike psychologists, social workers depend on psychiatrists for expressive rewards</li> </ul>
Piliavin, 1965	social workers, cottage parents	staffs in 2 juvenile treatment facilities (1 custodial, 1 therapeutic) were compared	<ul style="list-style-type: none"> <li>—poor communication between social workers and cottage parents (counselors) existed in both institutions</li> <li>—conclusion that groups should have greater proximity</li> </ul>

*Table 2 (continued)*

Reference	Professions	Methods	Major Findings
Styles, 1965	teachers, school psychologists	questionnaires returned by 459 teachers in 28 schools	Teachers thought that psychologists in schools were more clinically oriented and more expert in emotional illness than in fact was the case
Goldin, 1966	rehabilitation counselors	self-perceptions studied through ranking of other professions	<ul style="list-style-type: none"> <li>—83% felt rehab. counselor should do psychotherapy</li> <li>—group ranked own profession low in prestige, placing social work and teaching higher and nursing highest despite nurses' lesser education</li> </ul>
Goldschmid & Domino, 1967	psychologist, social worker, psychiatrist, teacher, rehab. counselor, attendant	questionnaire to 48 respondents in these groups in hospital for retarded	<ul style="list-style-type: none"> <li>—professions agreed on readiness for placement</li> <li>—professions disagreed on good candidates for psychotherapy choosing different qualities</li> </ul>
Olsen & Olsen, 1967	social workers, physicians	questionnaire on social work role	<ul style="list-style-type: none"> <li>—MD's grant fewer areas of responsibility to social workers than social workers wish to have</li> <li>—MD's underestimate social workers' expectations</li> <li>—social workers overestimate MD's willingness to grant them responsibility</li> </ul>
Robinson, 1967	public health nurses, social workers	questionnaire	—the more educated that both the social worker and PHN are, the less willing they are to collaborate or acknowledge each others skills

Table 2 (continued)

Reference	Professions	Methods	Major Findings
Sloane, 1967	lawyers, social workers	interviews of 11 lawyers and 11 social workers	<ul style="list-style-type: none"><li>—social workers distrust advocacy system and do not understand lawyer's role as representative of the law and preventor of law-breaking</li><li>—lawyers do not respect social work's body of knowledge, perceive workers as agency representatives, and do not perceive relationship as tool of social work</li></ul>
Peterson, 1968	chaplains, nurses, physicians, patients	questionnaire re chaplain's role	<ul style="list-style-type: none"><li>—groups agreed on traditional functions of chaplain, i.e., prayer, sacrament, worship, etc.</li><li>—MD's, RN's and patients do not grant clear-cut "psychoreligious counseling" role to chaplain and even chaplains disagree about this function</li></ul>
Stotsky, et al., 1968	physicians	1500 MD's, 150 psychiatrists and all psychiatrists in New England surveyed re rehabilitation knowledge and attitudes	<ul style="list-style-type: none"><li>—over 50% knew nothing of state rehabilitation services</li><li>—MD's rated social worker as most cooperative profession, rehabilitation counselor less highly and psychologist and educator least highly</li><li>—1/3 would refer handicapped patient to a social worker and only 1/6 to rehab counselor</li></ul>

Table 2 (continued)

Reference	Professions	Methods	Major Findings
Davis, 1969	social work, nursing	50 students from each profession studied	<ul style="list-style-type: none"> <li>—nursing students made career choices earlier</li> <li>—nursing self-image dependable, capable, methodical</li> <li>—s.w. self-image independent, spontaneous, curious</li> </ul>
Topf & Byers,	psychiatrist, psychologist, nursing, social work	content analysis of literature	<ul style="list-style-type: none"> <li>—The four professions in the mental health centers were sharing tasks in individual therapy, group therapy, supervision, education, consultation, research, family therapy and administration</li> </ul>
Brollier, 1970	social work, P.T., O.T.	Edwards Personnel Preference Scale; O.T.'s divided into medical and psychiatric	<ul style="list-style-type: none"> <li>—all groups similar on achievement and nurturance</li> <li>—social workers and psychiatric O.T. saw selves as autonomous, dominant, independent leaders</li> <li>—P.T.'s and medical O.T.'s saw selves as orderly, deferent, and as agents working in teams</li> </ul>
Hayes, 1970	social workers, public health nurses	Semantic differen- tial test	<ul style="list-style-type: none"> <li>—PHN's rated selves closer to their ideal professional woman than did social workers</li> <li>—nurses showed more hostility to social workers than vice versa</li> </ul>
Rehr, 1970	physicians, nurses and social workers	simulated cases and attitude questionnaire	<ul style="list-style-type: none"> <li>—none of groups thought collaboration needed in diagnostic phase</li> <li>—MD's do not support collaboration and tend to assign tasks to themselves</li> <li>—all groups saw paramedical help as most suited to lower class patients</li> </ul>

Table 2 (continued)

Reference	Professions	Methods	Major Findings
Smith, 1970	lawyers, social workers	Semantic differential; study in legal aid setting	<ul style="list-style-type: none"><li>-social workers do not accept legal function as primary in agency</li><li>-lawyers utilize s.w. inappropriately or ignore them</li></ul>
Sternback & Pincus, 1970	social workers, cottage parents	11 social workers and 50 cottage parents in 1 setting	<ul style="list-style-type: none"><li>-cottage parents evaluated inmate groups more accurately than did social workers</li></ul>
Williams, 1970	school social workers	mailed questionnaire	<ul style="list-style-type: none"><li>-of 83 behavioral items which s.w. could perform, 47 are performed in school considered "most compatible" and 15 in least compatible school</li><li>-interaction of s.w. and principal was most important in determining compatibility of school</li></ul>
Brennan & Khinduka, 1971	social workers, lawyers	questionnaire to 80 s.w.'s and 119 lawyers in juvenile court	<ul style="list-style-type: none"><li>-lawyers perceive selves as performing therapeutic tasks in post-adjudication phase</li><li>-social workers perceive selves as performing legal tasks in pre-adjudication phase</li><li>-s.w.'s incorrectly predicted congruent role expectations</li><li>-lawyers predicted incongruencies and perceived s.w.'s as expansionistic</li></ul>

Table 2 (continued)

Reference	Professions	Methods	Major Findings
Geertsma & Hastings, 1971	public health nurses, nursing and med. faculty, nursing and med. students, preventive medicine dept.	227 subjects; 5 factors derived from analysis of rating scale re role of PHN	<ul style="list-style-type: none"> <li>-PHN's and nursing students and preventive med. dept. positive to PHN role while MD, med. students and nursing faculty were negative</li> <li>-relationship skills and patient-orientation seen as major skill of PHN</li> </ul>
Banta & Fox, 1972	doctors, nurses, social workers	interview study in OEO health center	<ul style="list-style-type: none"> <li>-PHN's and social workers collaborated poorly</li> <li>-SW were cohesive as group but their supervisory relationships adversely affected team relationships</li> <li>-SW of higher socio-economic class than PHN</li> </ul>
Hyman, <i>et al.</i> , 1973	school psychologist, social worker, learning disability specialist	142 of these 3-men teams in New Jersey polled re conflict resolution	<ul style="list-style-type: none"> <li>-decision by psychologist and majority vote most usual ways of resolving conflict</li> <li>-psychologists generally satisfied; others not satisfied</li> <li>-s.w. most often in favor of majority vote; psychologist most often in favor of psychologist decision</li> </ul>
Powers, 1973	psychiatrists, social workers, psychologists	interviews of staff of child guidance clinics	<ul style="list-style-type: none"> <li>-s.w.'s underestimated what their colleagues expected of them</li> <li>-professions disagreed about role of s.w. but s.w. did not correctly perceive disagreement</li> <li>-perceived disagreement (not actual) related to dissatisfaction</li> </ul>

*Table 2 (continued)*

Reference	Professions	Methods	Major Findings
Randolph, 1974	aides, nurses, s.w., psychiatrist, psychologist, O.T.	therapeutic ideology scales	—hospital staff overall favors socio-therapeutic orientation —aides and nurses higher than others on psychotherapeutic scale
Schrager, 1974	MD, RN, SW, administrator	rating of social work tasks re desirability	—other professions' values for s.w. differed from s.w.'s own —others supported instrumental not expressive tasks in pt. care and service committees not policy committees —education not supported especially at med school level

Role overlap was also apparent in the way various professions defined their functions (Oviatt, 1964; Topf & Byer, 1969; Brennan & Khinduka, 1971; Randolph, 1974) but it is not certain whether this is a factor in the incongruities between self-expectations and expectations of others for the same profession. In general, given a list of tasks to assign, professions tend to designate most tasks to their own profession rather than to another. Rehr (1970) reported that physicians perceived a wide range of tasks as appropriate to themselves, including helping patients acquire financial assistance. Brennan & Khinduka (1971) indicate that the lawyer perceived himself arranging post-adjudication placements for children, while the social worker perceived himself performing legal tasks such as informing a client of his rights. These findings suggest that professionals on teams may become acquisitive and seek enlarged functions.

Professionals may not always realize that parts of what they consider their role (and feel they are in fact carrying out) are neither recognized in fact or accepted in principle by their teammates of other professions. Schrage (1974) shows that doctors, nurses and hospital administrators emphasize very different aspects of the social work role than those valued by social workers themselves. Olsen & Olsen (1967) found that physicians did not view as social work tasks such items as helping patients with social and emotional problems, helping the patient adjust to the hospital, or screening for psychiatric evaluation. Moreover, physicians did not predict that social workers would consider these their functions, while social workers generally believed that physicians would allow them primary responsibility for these tasks and expected them to carry them out. With such confusion, one wonders how a team process could function at all.

The studies overwhelmingly suggest poor communication between members of different professions. This seems true whether the setting is a general hospital (Rehr, 1970), a child guidance clinic (Powers, 1973), a neighborhood health center (Banta & Fox, 1972) or a mental hospital (Rushing, 1964). Incongruities exist between the way professionals perceive their role and the way their role is perceived by others. Seemingly the perceptions are not openly discussed and sometimes professions which sense that their version of their role is not accepted by colleagues misjudge the nature of the misconception. This lack of communication is noteworthy because of the finding (Powers, 1973) that professionals experience role dissatisfaction because of a *perceived* rather than an *actual* discrepancy between the way they and their colleagues view their role.

Several studies compare self-concepts of social workers to those of other professionals (Brollier, 1970) or social work students to other students (Davis, 1969); these indicate that in comparison to a nurse or physical therapist, the social worker views himself as autonomous and independent. Perhaps these characteristics are not conducive to effective cooperation on a team, especially if colleagues of other disciplines view themselves differently. On the other hand there is some evidence that social workers are less negative in reaction to other professions than are nurses (Hayes, 1970) and are more likely to take satisfaction from the approval of the psychiatrist than are psychologists (Zander, *et al.*, 1957; Rushing, 1964). Some findings also suggest that the social workers is more compliant and values the

team more highly than do some other colleagues. Stotsky (1967) reports that physicians choose the social worker as the most cooperative of listed disciplines, rating rehabilitation counselor lower, and educator and psychologist at the bottom. The social work respect for the team process is shown by Hyman's finding that, in the case of conflict on the school team, the psychologist would rather make the decision himself but the social worker prefers a team resolution with a majority vote if necessary.

An alarming finding (Robinson, 1967) indicates that the more educated a social worker or public health nurse becomes, the less willing they are to collaborate or recognize each other's expertise. Since education is the hallmark of professionalism, this suggests that the more "professionalized" practitioner is less cooperative with other disciplines. This result may be peculiar to the professions studied, however, since both the public health nurse and the social worker are relatively insecure in their professional identities. Zander (1957) found that professions are willing to collaborate and offer opportunity to members of another discipline when their higher status in relation to that discipline is secure. The nurse and social worker are in unsure positions as far as their relative relationship to each other in status and both are striving for recognition from the higher-status group, usually the physician.

The studies summarized and discussed in this section indicate conflict and role confusion among professionals. They suggest high risks of poor communication, unclear purpose and role definition, and status-seeking behavior on the part of members of interprofessional teams. The team interaction itself must now be scrutinized in order to understand how these role-related issues influence everyday practice. When particular teams are the focus of study, a host of process variables such as leadership, communication patterns, decision-making and participation are involved, and these may be structured differently from team to team. Such variables could exacerbate or minimize the potential for conflicts around role and status. The next chapter will turn to this subject, examining the team as a working group, and attempting to apply literature about small group processes to interprofessional teamwork.

### *Chapter III*

## **THE INTERPROFESSIONAL TEAM AS A SMALL GROUP**

The interprofessional team is a small face-to-face group, subject to the same laws and tendencies as any primary group. Yet it is often forgotten that much of the behavior of professionals on teams may be explained with the help of group process rather than solely by the interaction of professional roles and statuses.

### **SOURCES OF INFORMATION ABOUT THE TEAM AS A GROUP**

Data about the small group that may be relevant to interprofessional teams are derived from a variety of sources. In assembling material, the collator is faced with overlapping ideas which, nevertheless, are couched in rather distinctive language belonging to the originating group. Thus Eichhorn (1973) writes of "actualization of differences" on teams, Bernard and Ishyama (1960) study "ascribed and achieved authority" of team members, and New (1968) distinguishes between "functional and substantive rationality" underlying team functions. The welter of terminology confuses the reader attempting to find common conclusions in the work of the social psychologist, the social group worker, the sociologist, and the management theorist.

A rich resource for understanding the small group is the literature of group dynamics. In the 1940's and 1950's a prodigious amount of laboratory research was conducted on the workings of the small group; the findings from this work have been compiled by scholars such as Bonner (1959), Golembiewski (1962), and Berelson and Steiner (1964). Laws and principles regarding human behavior in groups may be extracted from these sources and tested for their applicability to the interprofessional team.

Some students of group dynamics have concentrated on task groups, particularly after Mayo and his colleagues demonstrated that work groups at Western Electric were subject to the same forces as any primary group (Koontz & O'Donnell, 1972). Social psychologists (Bales, 1950) have examined the process dimensions of the task group in considerable detail. Bass (1960) has spent much of his career studying the phenomenon of leadership and organizing its enormous literature.

Related research has emanated from the National Training Laboratory (NTL) and the T-group movement. The focus of this work has been understanding and improving the nature of communication in groups, to reach a higher level of empathy and creativity among members. Quite recently Odhner (1970), an occupational therapist, has attempted to extract from the T-group experience the content which is important to the interprofessional team.

Scholars associated with NTL were interested in the process of interdisciplinary research; some of the earliest insights into collaboration are derived from attempts to improve the process of the research team. An influential monograph (Luszki, 1958) grew out of an NTL-sponsored conference on the subject. The Sherifs (1969) have published work on this theme, and briefer articles are available by Eaton (1951), a sociologist, and Kaplan (1960), a social worker. Anthropologists, sociologists, psychologists, and physicians, to name some of the more frequent participants, have brought differing assumptions to the research task and the relationships have been further confounded by status differences. Researchers began to concern themselves with evolving a process that would minimize the obstacles to smooth and productive team study.

Social group work, an applied discipline, has incorporated many of the insights of the group dynamics and T-group streams (Hartford, 1972). In the last decade, however, group work has evolved theory more distinctly its own (Bernstein, 1965; Vinter, 1965). Although caution is necessary in extrapolating to the inter-professional team material originally formulated in the context of treatment groups, social group work has developed ideas about group formation, stages of group development, and the problem-solving process in groups which are applicable to the interprofessional team.

Some of the literature refers directly to team processes, often stimulated by the observation that interprofessional teams have been characterized by friction and misunderstandings (Banta & Fox, 1972; Silver, 1974). Wise's monograph on team process (1974) grew out of his experiences as director of a large neighborhood health center; discovering that the teams were dysfunctional, he called upon management consultants (Beckhard, 1972; Rubin & Beckhard, 1972) to advise on improving the process. From these earlier works, the Institute for Health Team Development took shape. Funded by the Robert Wood Johnson Foundation, this organization sponsors research into the nature of the health team and provides an information exchange through publication of a monthly newsletter (Health Team News, 1974). Under sponsorship of the Institute, Tichy (1974) edited an annotated bibliography of citations related to health teams. Eichhorn (1973), a member of the Institute with a background in nursing and organizational theory, recently published an account of the team processes of several student interprofessional teams undertaking summer projects in Appalachia.

Some research on team processes has occurred under the auspices of Comprehensive Mental Health Centers. The decision-making process has been examined (Rittenhouse, 1966a, 1966b), team morale has been studied (Dickey, 1963) and the leadership process has been given systematic attention (Greiff & McDonald, 1973). Such studies have been difficult to design because of the numerous variables and the problems of measurement but are an important source for understanding the team as a small group.

Another source is the literature concerning the intraprofessional team. Hierarchical teams have grown up in a number of professions including teaching, social work, nursing, and even psychology, and professionals have discovered that various aspects of their function may be entrusted to an individual with a lesser degree of

preparation. Within social work, the hierarchical team has been discussed in considerable depth (Gill, 1965; Barker & Briggs, 1968, 1969, 1971; Brieland, Briggs & Leuenberger, 1973). In such teams the goals are derived from the values of a single profession and the leadership is usually rather clearly allocated. Nevertheless the intraprofessional team has the same problems as the interdisciplinary team as far as the need to establish a harmonious and productive work unit. Conceptualizations from this area, as well as research (Anderson & Carlson, 1971), may fruitfully be considered to gain insights into interprofessional teamwork.

The remainder of the chapter assembles data from these diverse sources under nine topical headings, namely (1) the individual in the group, (2) team size, (3) group norms on the team, (4) democracy on the team, (5) decision-making, (6) conflict resolution, (7) communication and structure, (8) leadership, and (9) harmony and its relationship to productivity. Many of the categories overlap and the divisions are somewhat arbitrary. Decision-making, conflict-resolution, and communication are clearly related themes, and democratic processes are concerned with all three of these issues. In the discussions, furthermore, an effort was made to reduce the jargon of specialized fields, even at the risk of over-simplification.

### THE INDIVIDUAL IN THE GROUP

Team members are first individuals, later professionals, and much later, members of interprofessional teams. The individual characteristics of team workers such as age, sex, ethnicity, and geographic origin, may have been peripheral to the member's selection for the team yet may influence his experience on it. Some professions are associated with a particular sex or social class, making it difficult to judge whether the professional attributes or the personal ones most describe the team member's behavior and other's reactions to him. Horwitz (1970) considers that individual attributes of the team member may be as important as his professional affiliation in influencing team process.

Social group work has long emphasized the uniqueness of each group, since all groups are collections of unique individuals in dynamic interaction (Konopka, 1968; Trecker, 1974). To some extent, then, each team is an individualistic product of the backgrounds and characteristics of its members, even when the professional make-up of the team remains constant.

Reference group allegiances also affect individual behavior in a given group. An individual normally belongs to a number of groups simultaneously, and each of these affiliations will influence his behavior (Golembiewski, 1962). The member of the team has at least two reference groups—the profession and the team. In addition, he likely belongs to others, such as a religious group, a political group, an interest group, or a neighborhood group.

Summarizing research on how individuals reconcile conflicts between the dictates of their reference groups, Berelson and Steiner (1964) write:

When caught in cross-pressures between the norms of different groups of which he is simultaneously a member, the individual will suffer some emotional strain and will move to reduce or eliminate it by resolving the conflict in the direction of the strongest felt of his group ties [p. 329].

The implication here is that conflict between the mandate of the team and the mandate of the profession would be resolved in favor of whichever held the strongest attraction for the individual. It is unclear whether it is preferable, in the interests of ultimate service, for the major loyalty to lie with team or with profession. An excessive attachment to a professional reference group might render the team member inflexible and unresponsive in the work situation, on the other hand, attachment to the team might prevent him from applying the distinctive professional viewpoint which justifies interprofessional teamwork in the first place. This important issue requires research.

Although studies are imprecise on the matter of selection of compatible individuals to compose a team, some have tried to predict how specific individuals might interact with specific teams. Bernard and Ishyama (1960) studied the selection of mental hospital teams, reaching the conclusion that the personality of the staff member, the formal demands of the position, and the strivings for authority should be balanced in a given team. A psychiatrist with a low need for authority, for example, might be combined with a social worker with high interest in leadership. The authors concede that such predictions might be difficult to make but assert that application of their criteria could result in teams with less conflict since the needs and abilities of the members would complement each other.

Rushing (1964) reached a similar but more cynical conclusion in his detailed study of mental hospital personnel. Noting that psychiatrists tended to expect "a testing function" from psychologists and "a welfare function" from social workers, he observed that these role definitions were unacceptable to the high caliber professionals at the hospital. The author, therefore, suggested that despite the "American value and belief system that one should hire the best man available for a particular job [p. 256]," it might be conducive to the functioning of the organization to hire a more average or mediocre person. If the goals for a professional role are articulated at a minimal level, a less competent person might perform the job adequately and be more satisfied.

In summary, the fact that each individual brings to a group his personal attributes and his characteristic way of interacting stemming from his unique past experiences renders it exceedingly difficult to predict behavior of an inter-professional team. Such predictions must be made on the basis of more than a roll call of professional affiliations. Nevertheless, the fact that the profession as well as the team is a reference group for the individual must also be taken into account.

#### SIZE OF THE GROUP

Most commentators indicate that the ideal team should not be very large. Referring to the social work team, Brieland (1973) proposes five or six full-time members as an appropriate size. Luszki (1958) suggests that the interprofessional research team should remain rather small and not introduce too many disciplines so that conflicting views may be expressed and handled.

Research on the effect of size on group functioning (Berelson & Steiner, 1964) suggests that as the size of a group increases, greater demands are placed on the leader but the group tolerates direction from the leader better. The larger the

group, the more the active members tend to dominate and the passive members withdraw from participation. Furthermore, the larger the group, the less intimate the atmosphere, the more anonymous the actions of individuals, the longer it takes to reach decisions, the more acceptable unresolved differences become, the more subgroups form, and the more formal become the rules and procedures of the group.

This common-sense catalogue of differences with increasing size has applications to the interprofessional team. When critics suggest that the team is too large (Ellwood, 1968), they may be considering properties of large groups such as anonymity, formality and delay in decision-making. All these suggest that in the larger team the sense of commitment to and responsibility for actions may be diffused. On the other hand, all the advantages do not rest with the larger group; in a smaller group, unresolved differences are tolerated less, yet on a team differences must be permitted to exist if various professional perspectives are to be brought to bear on a problem.

Thelen has been credited with formulating a "principle of least size [Hare, 1962];" this law states that a group should be just large enough to include all individuals with relevant skill for problem-solving but no larger. There is a tendency to window-dress the interprofessional team (particularly if ample funding is available) so that it includes representatives of as many disciplines as possible without clear thought about each profession's potential contribution.

Related to size is the utilization of part-time personnel, a rather common practice on interprofessional teams. Four part-time physicians do not have the same effect as one full-time physician since the size of the group is so clearly altered by part-time personnel.

Perhaps the important issue related to team size is not the designation of an ideal number but the recognition of the properties of smaller and larger groups. With these properties clearly in mind, leaders and members could guard against potential problems related to size such as non-participation in larger groups and suppression of minority views in smaller groups.

### GROUP NORMS ON THE TEAM

Norms, for this discussion, are the standards of behavior and belief that a group imposes on its membership. Some groups exert a very strong influence on member attitude and behavior, while others have a lesser impact. Each reference group to which the team member belongs potentially may affect his judgment and conduct, depending on the strength of the group norms.

Certain norms have been considered counterproductive on interprofessional teams. Rubin and Beckhard (1972) indicate that a norm against conflict or against praise are both dysfunctional; the former impedes team members from expressing professional judgments while the latter denies members the support they might derive from the group. Another destructive norm calls for a physician to automatically become the team leader.

Members of groups adhere differentially to the group norms. The extent to which a team member will accept the norms is influenced by his status in the group,

which in turn may be influenced by his professional affiliation. Small group research (Berelson & Steiner, 1964) indicates that the more eager an individual is to belong to a group, the more he will conform to its norms. This suggests that the profession anxious to win a place on the team may be a conforming profession. Conformity to norms is linked to status in the following manner:

... the highest ranked and most secure members feel most free to express their disagreement with the group both privately and in public; the lowest ranked members are more likely to disagree privately but conform in public; and the average members are more likely to agree both privately and in public [p. 341].

Again the suggestion is that lower-prestige members will tend to conform unless efforts are made to increase their security. Another approach to gaining full expression would be for teams to establish a norm which encourages discussion and articulation of differences.

Group norms are also related to flexibility and openness to new input. Again drawing from Berelson and Steiner, the more stable a group is, the stronger are its norms. Furthermore, the less definite outside standards such as empirical evidence, science, religion, or morality are about an issue, the more free a group is to develop and then adhere to its own beliefs. Perhaps this accounts for the team which is strongly committed to an ideology or even a procedure with little evidence to support the position. If there is no firm conflicting evidence and if the group is cohesive, the team will be free to exact demands on its membership. If there is no basis for judgment by objective criteria and no stable group standard either, judgments tend to fluctuate and much more group time is required for interaction around an issue. It almost seems that strong group norms may become a short-cut to group process.

Since the desirability of such a short-cut is questionable, an argument can be made in favor of the shifts of membership which occur with team turnover. Without turnover, the group is stable, the members highly attached to the group, the norms firmly established, and the likelihood of shifting activities within the group more remote. It must be recognized, however, that the newcomer to an established group faces difficulties in becoming assimilated. Although social workers are aware from their treatment experience that a new group member requires help and support, it is often assumed that a new member of an interprofessional team can take the place of a former member as if he were an interchangeable part. Such a view ignores the fact that the group has already established norms for behavior that are unknown to the neophyte. Orientation to the team is a neglected subject but one which a knowledge of group process would suggest is important.

## DEMOCRACY AND TEAM PROCESSES

The democratic ideal pervades team literature; this concept is both the pride and the nemesis of the interprofessional team. Many writers (Eaton, 1951; Connery, 1953; Whitehouse, 1957) assume that the team should be a community of equals,

each member possessing a vote in the deliberations. The notion of democracy shapes the processes of decision-making, conflict-resolution, communication, and leadership on the team.

Although the official stance of many teams is to minimize differences between team members, this posture is difficult to maintain in practice. Research indicates that both patients (Silver, 1974) and team members (Oviatt, 1964) accurately perceive where power lies in the hierarchy even when the team is theoretically a community of equals. In sociological terms, New (1964) analyzes the cognitive dissonance occasioned by this contradiction, suggesting that "the myth of equality" in the face of differing responsibilities and competence is a source of serious strain for team members.

Democratic leadership, as opposed to authoritarian or *laissez-faire* leadership, has been highly valued by group workers. In terms of research findings (Berelson & Steiner, 1964), democratic leadership is characterized by durability, member satisfaction, group ability to pursue a task in the absence of the leader, and, possibly, greater productivity. It is also reported that the more persons associate together on equal terms, the more they share values and norms and come to like each other. If shared values and norms and friendship relationships are, in turn, associated with productivity, this would be an argument in favor of equality in the group. Certainly the presence of authoritarian leaders on the health team, mostly in the person of physicians, has been indicted as a major weakness of team delivery of health services.

During early phases of group development, a democratic process seems reassuring to members. Kaplan (1960) compares the initial processes of the interdisciplinary research team to a town meeting; independent work is discouraged and decisions are seldom reached. Eventually this process becomes unsatisfying to the members, who crave some role delineation so they can proceed with their work. Luszki (1958) makes a similar point in her observation that at the very least each team member requires explicit recognition of status differences in the hierarchy. Bartlett (1961) also opts for role clarity in pointing out that one of social work's tasks on the health team is to "recognize the middle-level status of social work [p. 171]."

Garland, Kolodny and Jones (1965) recognize a struggle around equality as a stage in the development of the small group. As these authors formulate it, most groups experience an early period in which power and control are crucial issues and in which problems of status, ranking and influence are paramount. This stage ends in a period of intimacy and sense of belonging and, from there, the group moves to a stage of differentiation, in which members are able to appreciate each other's uniqueness. Perhaps teams which constitute themselves as miniature democracies and do not move beyond this emphasis are fixated at an early stage of group development.

Odhner (1970) comments that a democratic structure may ward off some of the anxiety that goes with individual responsibility. He insists, however, that "we cannot avoid the anxiety of being evaluated by recasting the janitor as psychotherapist [p. 487]." Underneath the current deliberate role-blurring on

teams, Odhner detects an unwillingness to assume a role and be held accountable.

A useful distinction has been made between political democracy, which implies a time-limited delegation of powers, and social democracy, which concerns making judgments on the basis of the speaker's merits rather than his status (Binner, 1967). The team is not a political democracy, and, ironically, a social democracy accentuates inequalities. If all individuals have a right to speak, they will produce ideas of varying merit.

One cannot argue against a team process which facilitates participation according to ability and treats each member with courtesy and respect. The use of democratic slogans, however, often leads to a confusion of team processes with political rights and processes. The ambiguity and sometimes inaccuracy of the term democracy as applied to the interprofessional team complicates clear communication from the outset; probably the term should be abandoned.

### DECISION-MAKING ON THE TEAM

By its very nature, the interprofessional team permits several persons to have input into a given decision. The input may vary from very slight participation to an extreme which would insist that all decisions be made by the deliberations of the entire group. The American value system holds that wisdom resides in the group (Thelen, 1970); this belief is buttressed by research (Hall, 1971) which suggests that a group can generally reach a sounder decision than can individuals working alone. Furthermore, if the group is given some instruction on how to proceed with efforts to reach a consensus, the performance is even better. Apparently decision-making in a group is a skill which can be learned and improves with practice. In some instances, however, the decisions of a cohesive group may not be as accurate or perceptive as those of an individual uninfluenced by colleagues. Janis (1971) describes a phenomenon which he calls "groupthink." Observable in policy-making groups at high government levels, groupthink is characterized by a strong bond between members and well-developed group norms. The group is also sheltered from outside input, so that group consensus becomes associated with truth in the minds of members. In such cases, the assumptions behind a policy are not questioned even when the policy is obviously not yielding desired results—saturation bombing of North Vietnam is cited as an example.

A problem often found is simply the absence of any planned process for decision-making on the interprofessional team. In the absence of a procedure, and in a milieu which stresses the wisdom of the group, Luszki (1958) notes that decisions are sometimes reached prematurely through a process of "pseudo-consensus."

Guidelines have been suggested for a team decision-making process. It has been proposed (Rubin, 1972) that for each decision a determination be made around (1) who has the necessary information to help make the decision, (2) who must be consulted before the decision be reached, and (3) who should be informed after the fact. Most analysts concur that work groups do not require unanimity on all decisions, nor do all members need to participate on all issues. Binner (1967) points to three factors which could limit a member's decision-making participation in any

instance, namely, time, interest, and competence. He advocates a process which places responsibility on each team member to offer a dissenting view rather than wait for it to be politely solicited. Thus, hearing no opposition, a leader should be able to assume general agreement.

The team must, of course, have actual power to make decisions. Teams are hamstrung if they need to refer to an external authority, even in the same organization, for day-to-day decisions. Hogan (1968) cites as an advantage of the team structure within prisons the fact that decision-making can be decentralized to the team level. This view is compatible with Beckhard's (1972) that in any organization decisions should be made as close as possible to those with the necessary information.

A useful rule-of-thumb (Briggs & Van Voorst, 1974) is that the entire team should make decisions which affect the entire group. These might include formation of new policies or procedures, or the hiring of a new team member. Technical decisions should be made by those with the expertise in and responsibility for that aspect of the work. In helping a team reach wise decisions, a leader or member can profit by social group work insights. Lowy (1965) points out that the group worker can help members recognize the issues involved in various decisions, organize a search for tentative solutions, form subgroups to increase involvement in the decision, and direct evaluation of the decision.

Sullivan (1972) points out that team members should not expect total satisfaction with every decision, but should instead use as a criterion their willingness to commit themselves to the implementation of the decision.

Rittenhouse (1966b) observed the decision-making process of a mental health team over the course of 22 weeks. The team struggled with 9 policy issues, reaching decisions for only 2 of them. This 22% effectiveness on reaching closure was even more distressing since the ability to reach a conclusion was associated with leader initiative and the intensity of emotions related to the issue. The unresolved problems tended to be introduced by lower-prestige team members and discussed with less intensity.

An interprofessional team must reach decisions around establishment of goals, choice of strategies, delegation of tasks, and evaluation of outcomes, as well as around the crises which flare up from time to time. In summary, a decision-making mechanism seems necessary and input from many members of the group seems to increase the likelihood of a correct decision as long as the group process permits introduction of new input and open discussion. Highly technical decisions should be made by those with the expertise needed to do so; decisions which effect the whole working environment should be made with complete team participation.

### **CONFLICT RESOLUTION ON THE TEAM**

Conflicts are inevitable in the course of team decision-making. As Northern (1969) states, conflict and cooperation are part of the same phenomenon. Both are aspects of problem-solving and the group is a problem-solving medium.

Much literature of the interprofessional team is concerned with decreasing tensions and disagreements to produce an integrated group. This emphasis on

cooperation may, unfortunately, have obscured the fact that honest disagreement is not only permissible but essential for the team. Hiltner (1957) points out that, while unrelieved tension would be unbearable, unacknowledged tension produces cooperation yet sets a pattern for "perpetuation of basic mistrust and misunderstanding [p. 328]."

Bernstein (1965) discusses conflict from the group worker's perspective, suggesting that resolution may come about by domination by the stronger faction, by compromise solution, or by integration. This latter alternative, which calls for forging a new and acceptable synthesis, is considered most desirable. Conflicts may be resolved on different levels ranging from physical violence, verbal violence, subtle verbal violence, search for allies, appeal to authority, diversive and delaying tactics or respect for differences. Although all but, hopefully, the first two, have been known on the interprofessional team, the last level is clearly preferable.

Suchman (1963) suggests a five-point program for reducing levels of conflict on teams, including (1) a built-in process for review of decision, (2) opportunities for each member to develop a working knowledge of each other's field through planned mutual instruction, (3) autonomy for the social scientist on the team in the conduct of his research, (4) role clarification whenever possible, and (5) improvement of the interpersonal skills of the members (p. 197). The last point underlies what is believed by many therapists, namely, that processes for handling conflict can be taught and learned.

Observing five interprofessional student teams in great detail, Eichhorn (1973) noted the process of differentiation between the different specialists on the team. All teams began with a strong commitment to sharing and equality, and each experienced an angry crisis, after which the participants moved to clearer definition of professional and personal roles. Eichhorn's framework for this process involves three stages; (1) differences are suppressed and the team does not utilize its full range of problem-solving potential, (2) conflict occurs, individuals identify their own interests and needs and tensions are released, (3) differences are now legitimized with a new structure to accommodate them. In this last stage, called "actualized heterogeneity," differences are utilized as a resource.

In summary of this section, seemingly, various steps can be taken to minimize unnecessary conflict, such as role clarification, clear information exchange, and procedures for making and reviewing decisions. Some conflict, however, is necessary and should be clearly permitted in order to gain access to the full range of skills of the team members. As Leuenberger (1973) indicates, conflict management rather than conflict suppression should be the goal.

## COMMUNICATION AND STRUCTURE ON THE TEAM

Communication, in all its forms, verbal and written, formal and informal, structured and unstructured, is the vehicle through which the team members interact and the work gets done. The term is used here in its broadest sense to encompass both the kinds of messages transmitted and received, the persons involved in various communications, the language used, and the structural arrangements which guide and control the flow of information and feeling.

Ongoing communication is a time and energy consuming process. Team members must arrange their schedules so they can meet in the total group and in subgroups. On one group of teams (Silver & Stiber, 1957) at least five hours of each professional's time per week was devoted to communication within the team rather than direct patient service.

Interteam communication can be facilitated. Physical proximity of team members is desirable (Barker & Briggs, 1969), as well as a good clerical system and a clear, accessible record-keeping procedure. Brieland (1973) has even suggested that members of the intraprofessional team might share a large office with single adjoining rooms available for interviewing. Such an arrangement is not calculated to meet status needs of members but would enhance communication. Brieland also avers that, by permitting observation of each other's work, it accentuates the idea of team responsibility in the minds of both team members and clients.

It has been suggested (Beckhard, 1972) that team members should not report upwards to professional departments. This is contrary to the usual practice in social work, nursing, and other professions in large organizations. Weiner (1958), considering whether the social group worker in the hospital should participate with caseworkers in the social service department, decided in the affirmative. This simply illustrates that there may be compelling reasons for a strong tie to a professional department as well as to the team. The departmentalization does, however, dilute the team focus. The social work practice of providing extra team supervision for young workers has been shown to have a detrimental effect on the cohesiveness of interprofessional teams (Banta & Fox, 1972; Silver, 1974). Writing about teamwork in institutions for youth, Vorrath and Brendtro (1974) assert the principle of "teamwork primacy." The team, in their view, is the highest administrative priority; departments and extrateam supervision are eliminated.

Professionals are often exhorted to eliminate esoteric language on interprofessional teams (Luszki, 1958; Horwitz, 1959, 1970). Each professional should strive to express his goals and plans in a straightforward, comprehensible way. As stated earlier, a basic mistrust sometimes underlies an unwillingness to part with special jargon. Team communication is enhanced if all members contribute to the same record; various innovations have been proposed to accomplish this goal (Grant & Maletzky, 1972; Kane, 1974; Woolley, Warnick, Kane & Dyer, 1974). New record-keeping systems meet with resistance, however, unless the various professionals are willing to remove the mystique from their work.

According to research findings about communication patterns (Berelson & Steiner, 1964), one-way communication, as opposed to mutual communication, is less accurate and produces less confidence in the group. Feedback apparently increases accuracy. Centralized communication through a single point produces satisfaction at the center of the group but not at the periphery, permits task efficiency and coordination of contributions, clearly identifies and establishes the leader and restrains criticism in the group. With centralized communication, there is more chance of error and less likelihood of correcting it. Like the previous discussion on team size, both the centralized and decentralized patterns have strengths and weaknesses. Centralized communication is beneficial for clarifying

structure and coordinating the task. Yet unless safeguards are introduced, error may arise. Perhaps the solution is centralized communication with opportunity for feedback. Beckhard (1972) has recommended that each team designate a person as team manager; this would be an individual with skill in group process and through him, information might be directed. Some degree of centralization seems necessary yet it is imperative that communication be mutual and two-way.

Horwitz (1970) differentiates between "station-to-station" communication and "person-to-person." The former style is characterized by formal meetings and written memoranda, while the latter is much more interactive. Very large teams require some station-to-station communication to keep members informed. Horwitz then describes two distinct team structures of which communication style is only a part. The first pattern, called coordinate, consists of a team with distinct roles and functions for its members and rather separate, although coordinated, activities. The other pattern, called integrative, is structured so that the work of the different professions is interdependent, interaction is frequent and informal, and members assimilate something of each other's skills. On an integrative team, for example, members can usually substitute for an absent member with minimal disruption. In presenting this classification scheme, Horwitz suggests that much more study is needed to determine which structure is more appropriate for which tasks. Such a stance is much more helpful than an automatic endorsement of the integrative model.

Rubin and Beckhard (1972) claim that "team practice cannot work if roles talk to roles; a much more personal mutual dependency is required [p. 326]." It is true that team members must be able to communicate with each other as persons, yet it is also important that roles must be understood, communicated and reviewed. They cannot be ignored in a vain attempt at democracy and humanization. Members can learn to communicate empathically within a structures of roles. Only then can they learn, as Hiltner (1957) suggests they must, to enter imaginatively into the meaning of an experience to a member of another discipline.

Research in small group processes (Bales, 1950) indicates that task groups alternate between communications that deal directly with the task to be performed and those dealing with emotional and social relationships between members. Rittenhouse (1966a) has applied a version of Bales' scales to the mental health team and found a pattern of communication which consisted of many questions and attempted solutions, little effort to evaluate proposed solutions, and very little supportive communication. The author felt that this interaction promoted neither the task goals nor the emotional goals of the group.

Since teams are often found in bureaucratic organizations, linkages of communication must be provided to the larger system in which the team is housed as well as to the community as a whole. As an approach to the care of the chronically ill, it has been proposed (Katz, Papsedero & Halstead, 1974) that teams be formed as "modules" which are attached to and utilize the backup services of larger institutions. In any event, each team must design its communication system to allow for input from the outside. The outside is likely to include a host agency, a client group, the community, and the organizations of the various professions represented on the teams.

## LEADERSHIP ON THE TEAM

Leadership is a complex subject which has been studied extensively (Bass, 1960; Petruccio & Bass, 1961). For this discussion, leadership is defined as any conscious act of influence over the behavior of another. A group, therefore, may include many members who sometimes act as leaders in addition to a designated leader. In order to influence behavior, the leader must understand human motivation (Koontz & O'Donnell, 1972). On the other hand, the leader must also understand the nature of the task in which the team is engaged and exercise judgment about proposed actions. As Katz & Kahn (1966) indicate, leadership ability in the sense of persuasive interpersonal skills is worse than no leadership at all if exercised on behalf of an ill-judged cause.

Leadership, then, is a combination of goal-directed abilities and interpersonal skills. Research has indicated (Berelson & Steiner, 1964) that a leader will be followed more faithfully if he permits members to achieve personal goals as well as group goals. Leadership must satisfy the member's need for guidance and initiative and also for harmony and acceptance. In other words, both an intellectual and a social leadership are required, and these two attributes are rarely met in the same person.

According to the Rubin and Beckhard (1972), the leaderless team is a myth, although acts of leadership may be performed by many members at different times. A designated leader should handle the group process in a way which encourages leadership contributions of others. Vorrath and Brendtro (1974) call for rotation of team leadership in youth-serving institutions. They believe that "if a staff member is unable to serve in rotation as chairman, he probably should not be leading young people [p. 141]." This suggests the need to cultivate a minimum of leadership ability in all team members, but begs the issue that some persons, regardless of professional background, show a propensity to lead. Smith and Krishef (1972) report that in deliberately "leaderless" student intraprofessional teams, the undergraduate level students exercised more leadership than the students at masters or community college levels.

Automatic leadership of a physician, a psychiatrist, or a person with seniority has not enhanced the processes of interprofessional teams. Sometimes new professions are proposed for leadership without thought for preparing them for the task. For example, one agency appointed public health nurses as team leaders only to find that they were not ready to assume that responsibility (Wise, 1974). A better suggestion is that the leader should be chosen, not on the basis of his professional affiliation but on the basis of his understanding of and skill in utilization of group processes on behalf of group goals. There is some evidence, too, that facilitative leadership skills can be taught (Douglas & Bevis, 1970; Carlaw & Callan, 1973; Wise, *et al.*, 1974).

Even this brief discussion suggests that many interprofessional teams are in violation of what is so far known about leadership. On the team responsibility for leadership process often rests with the most educated member who may also carry responsibility for the task. Sometimes the team is formed with the plan that there will be no leader and that each person will carry equal responsibility. Rittenhouse

(1966a) examined a team which claimed shifting leadership, finding that in fact leadership tended to reside in the same person across a variety of tasks. It is apparently not enough to declare that all team members are leaders in their own sphere unless a manager-leader facilitates a process which encourages that development.

A recent study (Greiff & McDonald, 1973) examined the interactions of psychiatrists and team leaders on teams which did not utilize the doctor as the team manager. Although the sample is too small to draw many conclusions, this pattern of non-physician leader worked out fairly well. Many areas of disagreement between the physician and non-physician leader existed but the teams managed to perpetuate the pattern.

In summary, leadership must be consciously and skillfully exercised and be directed both to the goal fulfillment and the personal satisfaction aspects of the team. The best leadership is one which will allow other members to exercise leadership around particular areas of expertise; it seems that such an outcome cannot be left to chance but is best achieved when someone with facilitative leadership skill is designated team manager.

#### **GROUP HARMONY AND ITS RELATIONSHIP TO GROUP PRODUCTIVITY**

Much of the opinion about processes such as communication and decision-making on the team is predicated on a view that the team will perform its task better if the working environment is pleasant and congenial. This is not a certain fact, however, and the relationship between group harmony and group productivity is questionable.

Consolidating group findings, Berelson and Steiner (1964) report that both the effectiveness and the satisfaction of a group increase when members find their personal goals met as well as the group objectives. Hare (1962) indicates that groups with a high degree of interteam friendships will generally be motivated to try harder and be more productive (p. 375). Commentators on the intraprofessional team (Gill, 1965) and the interprofessional team (Binner, 1967) agree that a harmonious team reduces energy spent on conflict, freeing it thereby for goal-directed activity.

As already indicated, every group must give attention to its own processes as well as the completion of its tasks. On the other hand, too much attention to group maintenance is counterproductive, simply in terms of use of time. An analogy might be made to the maintenance of a car; some routine servicing helps the car function and prevents future breakdown, but if the car is constantly being serviced, its effectiveness for transportation is reduced.

Berrien (1961) has evolved a formula for balancing formal achievement (FA) and group need satisfaction (GNS) within a group. Both FA and GNS are operationally definable and measurable; an optimum balance between the two, or homeostasis, is associated with an effective group. According to Berrien, some indicators of homeostasis are group cohesiveness, satisfaction of members with leader's interpersonal relationships, satisfaction with leader's technical skills, satisfaction with tangible rewards, and member pressure towards remaining in the group.

In general, the data on harmony and its association with effectiveness are

complicated and somewhat contradictory. Certainly a group which places its harmony ahead of its task will not be effective. Bass evokes a familiar situation to underscore this point:

... meetings faces with difficulties could achieve a high degree of consensus and good feeling by postponing complex problems and tackling only simple agenda items. Solution of these simple items give a sense of task accomplishment, although the major success occurred in achieving satisfying interaction [Bass, 1960, p. 33].

Other pertinent data come from Janis' (1971) studies of advisory groups such as those counseling President Kennedy prior to the Cuban missile crisis or the American Command in Hawaii prior to World War II. These groups were harmonious to a fault; members respected each other enormously and were so supportive that consensus came to be associated with truth. No contingency plans were made, original premises were never questioned, and no outside opinion was solicited. Remedies suggested to prevent such a situation include leader activity in the direction of seeking outside experts, inviting team members to play the devil's advocate, deliberately postponing decisions, and refraining from lending the leader's weight to early solutions. Such leader behaviors are clearly geared towards goal achievement rather than group need fulfillment, and necessarily so.

The scant empirical research relating to morale on a team vis-à-vis productivity is inconclusive. Dickey (1963) studied the association between team member morale and the amount of time the member spent working with patients. She found a high correlation between good morale and time spent in formal patient interviews and admission workups. The association did not persist for informal patient contacts, leading one to speculate that perhaps these contacts had not been fully incorporated as a group norm. Anderson and Carlson (1971) report rather different findings from the Midway study of intraprofessional teams in public assistance. Individual job satisfaction was not associated with high productivity, defined by frequency of contact with clients and number of home-visits. A profile of those who were highly productive indicated that this worker tended to be young, newly employed, and disinterested in a career with the agency. The authors concluded that such a worker is better able to resist the norms of the group which called for a more leisurely pace. One is then reminded of Kurt Lewin's famous dictum (Hartford, 1972) that it is more feasible to change an entire group than an individual within it. Perhaps the effort to increase productivity is best handled through group discussion, reeducation, and decision-making than through attempts to supervise and influence individuals, making them deviants from the group at the same time.

The professional who wishes to facilitate team productivity cannot ignore interpersonal relationships, but he must also be aware of the task focus of the group. Referring primarily to therapy groups, Vinter (1965) emphasizes that the group is both the means and the context of treatment. The leader can facilitate the achievement of group goals through recognition and use of four characteristics that all groups share; these are (1) social organization into roles and statuses, (2)

activities and tasks, (3) group culture and norms, and (4) relationship to the outside world. The interprofessional team is both the means and the context of problem-solving and its leader might profitably remember Vinter's four points.

The relationship to the outside world is an aspect that may be forgotten. Perhaps it is incumbent on the leader of a cohesive interprofessional team to remind members occasionally of the team's relationship to outside forces, just as it is necessary for him to protect the team from too much outside interference. In his study of the processes of WIN teams, Marcus (1973) suggests that cohesive, highly integrated team units have the advantages of good communication and confidence in teammates but corresponding difficulties of isolation and lack of integration with the larger social system. In his elaborate theory of human need, Schutz (1961) supports this view. He suggests that each group member needs a certain amount of control over events inside the group but not too much power, a certain amount of control over outside events but not too much autonomy, and a certain amount of intimacy and inclusion, but not too much. Presumably the leader who can balance these delicate forces will acquire both a happy and a productive group.

### CONCLUSION

This chapter has touched on a number of inter-related components of the group process which are pertinent to the interprofessional team. More variables could have been considered, yet the long list already suggested is long enough to create practical problems in deciding which issues are of greatest importance to the team. Choice of variables is a dilemma for small group researchers in general. Some years ago, Golembiewski (1962) concluded that this is a major challenge:

A considerable volume of future work must be accomplished in two general areas. The first area is the clarification of existing concepts and operations and the determination of the degree of overlap of existing variables allegedly tapping the same or similar phenomena. The second area requires that the variables utilized be pared down to a small number. Thus far, however, students have not demonstrated great interest in consolidating work. If small-group analysis is not to bog down in a morass of variables, research tastes must change [p. 286].

Analysis of interprofessional teams is at an early stage as far as research is concerned, yet probably should profit by Golembiewski's warning. The study of the team must include variables of profession and purpose as well as group process variables. The more the total list can be reduced in number the more readily practical conclusions can be drawn. At present, however, there is little basis for consolidating or eliminating variables. A broader, more detailed scrutiny of team practice is needed as a prelude to experimental research. The study reported in the next chapter is hopefully a beginning in that direction.

## Chapter IV

### A PROFILE OF INTERPROFESSIONAL TEAMWORK

Although team practice has been prescribed for the professions, it has yet to be adequately described. The experience of thousands of interprofessional teams in a variety of settings and fields is either buried in the professional journals of different disciplines or remains unrecorded. New departures in team processes are announced from time to time, but there is no cumulative information to describe interprofessional teams as they now exist. The author, therefore, decided to review accounts of teamwork in professional journals in an effort to describe current team practice.

Thirty representative periodicals of different professional groups and interprofessional fields were examined issue-by-issue for the decade 1964-1973. The choice of journals for review reflects (1) comprehensive inclusion of social work journals, (2) representation of journals of interdisciplinary fields, such as public health, mental health, geriatrics, corrections, and learning disabilities, and (3) representation of the journals of those professional groups with whom social workers collaborate most frequently on teams. In this last category, medicine, psychiatry, psychology, nursing, occupational therapy, and law were included.

A hand search of the issues of the 30 journals yielded 229 articles which described a service rendered by an interprofessional team. In most instances the primary thrust of the article was not delineation of team processes, yet this sample did provide an unobtrusive method of viewing team practice.

For each article in the sample, a systematic protocol was completed; through this instrument data were collected regarding team membership, purpose, ideology, various dimensions of group process, social work role on the teams, and the nature and extent of efforts to evaluate the team's effectiveness. The protocol yielded 56 variables which were transferred to computer cards for analysis. Chi-square tests of significance were applied with the level of significance set at .05.\*

#### THE TYPICAL TEAM

From the analysis of the 229 teamwork accounts, a typical team was described based on the modal category for each item on the research protocol. In this sense, the typical team is a group with 6-10 members, led by a physician, often a

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\*For more complete information about the methodology of the study including copies of the research instrument and a list of the articles comprising the sample, see Kane, R. A. *The Interprofessional Team (With Special Reference to the Role and Education of the Social Worker)*. Unpublished Doctoral Dissertation, University of Utah School of Social Work, 1975.

psychiatrist. Its primary purpose is direct service in the health field, although it may have some additional indirect goals such as education of personnel or patients or research in addition to its service function. The purpose of the team is stated in broad general terms, such as "the delivery of comprehensive, family-based health care," and thus is not readily measured.

Social work is represented on the team. So too are a number of paraprofessionals. Decisions are not made by team consensus but probably by the designated leader. The team adheres to the coordinate pattern, meaning the the professionals function in rather independent roles with some communication among them. A distinct role is allocated to each member profession. There is no evaluation procedure built into the team's performance although those administering the team are quite convinced that it serves the patients well. When the team is described in professional literature, the author is a physician discussing the advantages of the coordinated approach to care. Perhaps the team social worker will prepare a similar article for a social work journal while the team nurse will write about the team in the nursing periodicals.

On this team the social worker performs a function shared by no other professional. She (since the majority are women) spends most of her time doing casework with individuals and families, although she will often lead groups. Her activity is centered particularly around intake, screening and diagnostic services and around discharge and referral services. It is these functions at the gateway of the team that give her a unique position.

The above profile describes the most frequent team pattern which emerged from the study. Another kind of team was also evident, however, and in sufficient numbers to warrant comment. This team also has about 6-10 members and it too has a social worker among them. Paraprofessionals are very definitely part of this second kind of team. In this team, in contrast to the first, no leader has been designated or there may be a manager to direct the team process. Decisions are made in the group by consensus of the group and a considerable amount of role-blurring occurs. The team adheres to the integrative pattern, meaning that the team members function in an interdependent manner. The social worker is still involved in direct casework with an emphasis on intake and discharge planning, but no longer is she likely to perform a task that no other team member performs. When the team reports its activities in the professional literature, the different professional members tend to collaborate in authorship.

With these two composite team pictures to anchor the figures in reality, the sample may now be described with reference to the frequencies of the different variables.

#### **DESCRIPTION OF THE SAMPLE BY FREQUENCIES**

Two-hundred and twenty-nine articles were reviewed; of these 59% were authored by one or more members of a single profession and 41% were interprofessional in authorship.

For 200 of these teams it was possible to ascertain the team size. Of these 200, 34% were five member teams or less, 44% were 6-10, 9% were 11-15, and 12% were over fifteen in number.

Social workers occurred more frequently than any other profession on the teams. Table 3 indicates the frequency of appearance of the various professional groups on the 229 teams.

*Table 3*  
*Frequency of Professions on Teams*

Profession	No. of Teams	%	Profession	No. of Teams	%
Social Worker	189	82.5	Manager, administrator	22	9.6
Nurse	150	65.5	Recreationist	18	8.
Physician	126	59.4	Clergy	15	6.6
Psychologist	112	48.9	Researcher	8	3.5
Psychiatrist	94	41.	Pharmacist	6	2.6
OT, P.T., Speech therapy	65	28.4	Lawyer	4	1.7
Teacher	60	26.2	Engineer	4	1.7
Dietician, nutritionist	35	15.	Health educator	4	1.7
Vocational counselor	34	14.8			

Other professions which appeared infrequently on the teams included dentists, basic scientists (such as biochemists, geneticists, and pharmacologists), otologists, prosthetists, correctional therapists, an optometrist, and a librarian.

An effort was made to determine the frequency of professional combinations on the interprofessional team; this resulted in the discovery of 162 combinations in the professional makeup of 229 teams. Of the two-profession teams, the physician/nurse combination was most frequent, followed by the psychiatrist social worker, but there were numerous other arrangements. Of the three-profession teams, 23 combinations were identified; the most common of these was the physician/social worker/nurse combination with 18 examples followed by the psychiatrist/psychologist/social worker combination with 7 examples. In four-profession teams, there were 47 teams and 24 combinations; the most common arrangement was physician/psychiatrist/social worker/nurse with 7 examples. When examining the teams with five or more professions represented, the number of combinations increased and very seldom repeated themselves. The only conclusion that was drawn from this information was that the makeup of the interprofessional team can and does vary markedly from team to team.

The service type of the teams was almost completely direct service with only 10% primarily filling an indirect function such as prevention or education or planning. As already suggested, however, the teams tended to have both a primary service function and a secondary indirect function. The fields of service were represented in the sample in the following way: health, 51%, mental health, 28%, corrections, 8% education, 7%, and welfare, 7%.

Although it was possible to divide the teams into these areas of service on the

basis of the team's primary purpose and its host setting, it is noteworthy that some merging was apparent in the fields of human service. Health personnel appear on school teams, educators are functioning in prisons and in hospitals. One of the teams in the sample, to give an example of an unlikely combination, deals with the use of plastic surgery in corrections (Kurtzberg, Safar, & Mandell, 1969); surgeons, psychologists, social workers, vocational counselors and correctional officers are involved in the decisions about which disfigured offenders might benefit from cosmetic surgery. Similarly, several of the teams working with teenage unmarried mothers pointed to the need for educational, health, and psychosocial services to be combined together in the same functional team.

The teams tended to have paraprofessional members with 65.5% reporting this pattern and 34.5% reporting that they did not use paraprofessionals. Almost half the teams were guided by some overriding belief or ideology; 42.8% did have such an ideology, while 57.2% did not. Examples of ideologies might include belief in the therapeutic milieu, a conviction that the patient should be part of his own team, an adherence to operant conditioning principles, or some kind of belief about the etiology of the problem which the team is addressing. Only 14 teams or 6.1% were identified as adhering to behavior modification. Although a general purpose was stated for each team, 86.9% of the teams did not phrase the purpose in a way that the goal attainment could readily be measured. The 13.1% which did state a measurable purpose tended to include such goals as reduction in the incidence of a particular disease, decrease in hospitalization for mental illness, or job acquisition for unemployed. Such items could at least be measured for the population under consideration although it might be more difficult to prove that the team was responsible for any improvement in the record.

Several items around group organization and group process were explored. More often than not in these instances the information was not recorded in the article. For example, the record-keeping patterns of the team are of interest, since it is possible for a team to utilize a single record shared by all professions or to keep separate professional records. For 21 teams, it was reported that they did develop a single record for the use of all personnel. It was apparent that 5 teams utilized separate records for the professions and 203 (88.6%) did not indicate anything about the record-keeping system. While it is probable that the majority of this latter group fall into the category of separate professional recording, such speculation cannot be proved. Similarly the figures about affiliation with professional departments are also inconclusive because of the large gaps in information; 26.2% of the teams did exist within a professional department structure, 29.7% did not, and 44.1% did not afford the information.

In more than half the teams (54.6%) roles were distinct for the various professionals. In 34.9% the roles were overlapping, and for 10.4% this information was not recorded. In 18.8% of the teams decisions were reached by consensus of team members, and in 46.7% decisions were non-consensual, while the remainder were unrecorded. The coordinate pattern of organization was adhered to in 57.6% of the teams, the integrative in 27.1% and in 15.3% of the cases this information was unrecorded.

Leadership was a particular focus of the study. In 59.4% of the teams the leadership was assigned, in 8.8% it was unassigned or shifted in assignment depending on the case, and in 31.9% this information is unrecorded. In the latter situations it appeared that leadership had been assigned to a physician in many instances but it was not sufficiently clear to designate into the assigned category. The formal leader, in cases with leadership assignment, was identified by profession. Table 4 indicates the percentages of teams with leaders that fell to the leadership of any given profession. Physicians predominated as leaders. Fewer teams had psychiatrist leaders, perhaps because the leaderless team is more predominant in mental health. The "other" designation includes those teams with unusual leadership patterns which called for any member of the team with the ability rising to leadership. In such an organization one team may be led by a physician, one by a social workers, one by a nurse and so on.

*Table 4*  
*Formal Leadership of the Team by Profession*

Profession	Number	%
Physician	71	51.4
Psychiatrist	19	13.8
Social Worker	12	9.4
Manager, Administrator	10	7.2
Nurse	10	2.2
Psychologist	3	1.4
Educator	2	8.
Other	11	
Total	138	100.6*

\*Error due to rounding.

The process aspects of leadership were often unrecorded. In 25.8% of the teams there was indication that the leader was concerned for the group process as well as the task, while the remainder were either task-focused or the issue was not recorded in the article. Similarly in 26.2% of the teams, there was evidence of shifting leadership roles and in the remainder either the leadership remained invested in the assigned leader or the information was not recorded. An example of how leadership can shift even in a situation with an assigned leader is a psychiatrist-led team (Weisman, Feinstein, & Thomas, 1969) which appointed different leaders for each patient's treatment program. All team members including the paraprofessionals served as individual team leaders for particular patients, while the psychiatrist chaired the staff team meetings.

Of the 229 teams, 189 had one or more social work members. Information on the sex of the social worker is too incomplete to be useful; 35 teams had female workers, 13 had male workers, 11 had workers of both sex, and for 128 teams that

information was not available. In 57 of the 189 teams with social work representation, the functions of the worker were not specified; the breakdown of social work activities for the other 132 teams is shown in Table 5. Since more than one activity was possible for social workers on a team, the totals add up to more than 132. In addition to the activities listed on the table, social workers performed a few other functions on some of the teams such as a research role. For the 189 teams with social workers, the social worker performed a unique role on the team in 45% of the cases, clearly did not perform a unique role in 6.3% of the cases, and for 48.7% of the teams this information was not recorded.

*Table 5*  
*Social Work Activity on Teams*

Social Work Activity	Number of Teams	%
Casework with individuals and families	102	77.3
Referral, discharge planning	91	68.9
Community relationships	54	40.9
Intake, diagnosis, screening	53	40.2
Group leadership	49	37.1
Education, supervision, staff development	37	28.0
Administration	16	12.1
Planning, program development	14	10.6
Advocacy	6	4.5

The efforts of the team to evaluate their function were examined. The majority of the teams did not have an evaluation procedure reported other than subjective case examples of effectiveness; 121 teams (52.8%) fell into this category, while 46.7% had some measure of effectiveness in goal achievement, 9.6% had some measurement of consumer satisfaction, and 7.9% had some measurement of team member satisfaction.

The teams that reported an effort to evaluate almost always reported positive findings. In some instances an evaluation procedure had been set into motion but the results were not yet available. Very few negative findings were reported. Three teams did indicate some inefficiency compared to another modality and two teams indicated that there was some lack of satisfaction to team members.

#### CROSS-TABULATIONS

A number of cross-tabulations were performed to determine the relationship which existed between variables such as leadership, size of team, field of service and various process dimensions used as variables in the study. The N for these calculations was often less than 229 since the unrecorded data on the particular variable were excluded.

The authorship of the team was examined to determine whether a multi-professional authorship was more often associated with the integrative than the

coordinate pattern of organization. Table 6 depicts this relationship for the 187 teams on which data about pattern and authorship were available. The differences in pattern between the multiprofessional authorship and the single-profession authorship were statistically significant in the predicted direction.

*Table 6*  
*Authorship of Article According to Team Pattern\**

Authorship	Team Pattern					
	Coordinate pattern		Integrative pattern		Total	
	No.	%	No.	%	No.	%
Multiprofessional authors	44	58	32	42	76	100
Single profession authors	82	29	29	26	111	100
Total	126		61		187	

\* $p < .02$

Chi square = 5.24

The size of the team was compared across fields of service and no significant differences were found. In all cases the 6-10 person team was the most frequent size followed by the 0-5 category. In the welfare field only this trend was reversed with the largest number of teams containing eleven or more members. Since the total number of teams in the welfare field was small ( $N = 14$ ), it is hard to draw any conclusions from this finding. Table 7 presents the differences in team size according to field of service. Team size was also compared with the coordinate versus the integrative team pattern and no significant differences were found.

*Table 7*  
*Team Size According to Field of Service*

Team Size	Field of Service										Total
	Health		Mental health		Correc-tions		Educa-tion		Welfare		
	No.	%	No.	%	No.	%	No.	%	No.	%	
0-5	36	35	17	33	6	43	5	33	3	21	67
6-10	51	50	19	37	4	29	7	42	3	21	84
11+	16	16	15	29	4	29	3	20	8	57	46
Total	103	100	51	100	14	100	15	100	14	100	197

Comparing teams which has paraprofessional members to those that did not yielded some significant differences. Teams with paraprofessionals were more likely to adhere to the integrative pattern of service than the coordinate and were much more likely to have overlapping roles for team members. Table 8 and Table 9 report these findings. Table 8 shows the distribution by presence of paraprofessionals for those 194 teams which recorded the pattern of organization. Table 9 indicates the distribution of role allocation for those 205 teams for which that variable is available. As the latter table suggests the relationship between presence of paraprofessionals and overlapping of professional roles on the team is very strong. No significant relationship was found between presence of paraprofessionals and the decision-making process on the team. There was a tendency for the teams in the health field to utilize paraprofessionals less as team members than the teams in the other four service areas but this difference did not reach significance.

*Table 8*  
*Presence of Paraprofessionals According to Team Pattern\**

Paraprofessionals included	Team Pattern					
	Coordinate pattern		Integrative pattern		Total	
	No.	%	No.	%	No.	%
Yes	38	58	27	42	65	100
No	94	73	35	27	129	100
Total	132		62		194	

\*Chi square = 4.13  
p < .05

*Table 9*  
*Presence of Paraprofessionals According to Role Clarity\**

Paraprofessionals included	Role Clarity					
	Distinct roles		Overlapping roles		Total	
	No.	%	No.	%	No.	%
Yes	32	47	36	53	68	100
No	93	73	44	27	137	100
Total	125		80		205	

\*chi square = 8.28  
p < .001

Effort to evaluate was compared with field of service and here a strong difference emerged. Teams in the health field were significantly more likely to employ an evaluation procedure than those in the other fields of service. Table 10 presents these data, comparing the health field to mental health, and to corrections, education and welfare as grouped categories. Evaluation effort was not significantly correlated with the assignment of a formal leader, the form of decision-making, the goal focus versus the process focus of the leadership, or the shifting versus the single occupancy of leadership roles.

Originally, it was hoped that comparisons could be made between the different leadership styles of the various professions with an emphasis on the social worker as leader. Unfortunately the small number of social work leaders rendered these kind of interpretations very difficult to make. A pattern did emerge according to formal leadership, however, which differentiated those teams led by medical doctors (including psychiatrists) from those led by any other professional group. The analysis indicated that the teams which were physician led conformed more to the traditional pattern of leadership invested in a single person, non-consensual decision-making, distinct roles, and leadership focused on goal attainment rather than group process as well. Tables 11 and 12 indicate some of these trends as they affect role clarity and decision-making patterns. The tables show relationships which are statistically significant. Similar tables could be presented to show that the physician led teams are more likely to be directed exclusively to goal attainment rather than to group process as well and that physician-led teams are more likely to invest their leadership in a single person.

*Table 10*  
*Evaluation Effort According to Field of Service\**

Evaluation effort	Field of Service							Total
	Health		Mental health		Other fields			
	No.	%	No.	%	No.	%		
Yes	46	55	30	48	30	62	106	
No	69	45	32	52	18	38	119	
Total	115	100	62	100	48	100	225	

\*chi square = 6.94

p < .03

*Table 11*  
*Formal Leadership According to Role Clarity\**

Formal leader	Role Clarity					
	Roles distinct		Roles overlapping		Total	
	No.	%	No.	%	No.	%
MD	60	71	24	29	84	100
All other	65	53.7	56	46.3	121	100
Total	125		80		205	

\*chi square = 6.53  
p < .01

*Table 12*  
*Formal Leadership According to Decision-Making\**

Formal leader	Decision Making					
	Consensual decisions		Non-consensual		Total	
	No.	%	No.	%	No.	%
MD	10	14	59	86	69	100
All other	33	40.7	48	59.3	81	100
Total	43		107		150	

\*chi square = 12.53  
p < .001

## DISCUSSION

### Implications for Team Process

The data suggest that several patterns of interprofessional team exist. Although the teams with a designated leader and fairly clear role demarcation still predominate and are especially more numerous in the health field, teams with no leader or a managerial leader who shares responsibility are also quite common. These latter teams tend to reach decision by consensus and to be engaged in interdependent activities with considerable role-blurring occurring among the professionals.

The two opposing patterns of team have been designated as "coordinate" and "integrative." An example of a coordinate team is provided by an interprofessional unit serving the laryngectomy patient (Johannessen & Fey, 1964); each profession on this team is considered important to the overall rehabilitation of the patient, yet each tends to enter the situation at a different point in time with a rather specialized role to perform; and the physician remains a leader figure. The dietitian is required after the surgery, the occupational therapist is required prior to surgery to teach the patient how to communicate without language, and the social worker is needed quite a bit later in the process around adjustment to discharge, while the speech therapist is constant throughout. The proponents of the coordinate team (Ellwood, 1965) emphasize that the patient can readily become confused in a role-blurring, interprofessional team with an emphasis on consensual decision-making. Shared decisions, Ellwood claims, are "psychodynamically satisfying for the team but therapeutically disastrous for the patient."

The integrative team, in contrast, adheres to shared decision-making, overlapping roles, shifting leadership focus, and attention to team group processes as a desirable way of operating. In an integrative team it is frequent that the entire team makes home visits together (Kemp, 1971), that professionalism is levelled (Phillippus, 1968), and that different professions take turn assuming leadership according to the needs of a particular patient (Lief & Brotman, 1968). It is not unusual for an integrative team to develop a pattern which calls for a meeting of the entire team with patient and/or family to discuss the team's findings (Weinstein, 1968). In an integrative team, too, team members are willing for the patient to choose their own primary therapists from the team. For example, in a team serving adolescent unmarried mothers (Smith, Duncan, Shouse & Brown, 1971) each girl was assigned to a basic team of nurse, social worker, and teacher and was free to decide how she wished to use these persons.

The integrative model seems to afford flexibility, and this attribute is part of its appeal to its proponents. No team member is so fixed in a role that he cannot respond to client need, or even team need because of personnel shortages or changed circumstances. Certainly it was apparent in reading the accounts of integrative teams that many of the innovations in practice have occurred within this pattern. Inclusion of the patient as a team member, imaginative use of paraprofessional personnel, shortening of traditional hospitalizations or diagnostic periods are instances of changed practice developed within an integrative team structure.

The presence of paraprofessionals as accepted full members of the team was found to be correlated with consensual decision-making and role blurring to a significant degree. The data do not permit a guess as to which aspect is causal; it may be that teams which permit flexible overlapping roles and shared decisions are also more willing to include paraprofessionals in their deliberations, but it may also be that the visible presence of paraprofessionals makes it more difficult to maintain clear professional role demarcations.

Interprofessional authorship was found to be significantly correlated with the

integrative team model. This finding is predictable; if the team functions as an interdependent, highly interactive unit, one would expect the members to collaborate in writing about the team. It may be, however, that work together on articulating the team's purpose and activities for a professional audience would strengthen the bonds between the members. Perhaps a team manager desiring a cohesive, integrative unit might consider the strategy of asking the group to prepare an article about its activities.

Many process dimensions of the team were missing from the team accounts. This was particularly true of items such as record-keeping or departmentalization. Record-keeping is a very important part of intrateam communication and surely deserves more attention than it receives in the literature. In this study, 88.6% of the teams did not give any indication of their recording procedures. Similarly, 44.1% gave no information about whether the team members were also members of professional departments. The question of departmentalization is possibly an important one; several of the articles in the study highlighted an effort to become patient-centered rather than department-centered (Cortazzo, Bradke, Kirkpatrick & Rosenblatt, 1971; Gerard, 1970). Some organizations, particularly in the correctional settings, abolished traditional departments (Hogan, 1968; Levinson & Gerard, 1973) and gave authority to decision-making interprofessional teams. The question of how the professional relates to his own professional group and to his team group is important, yet not widely reported in journal accounts of teamwork.

The issue of departmental structure is also related to the problem of who provides professional education and supervision to the employees of the team. Several of the teams reviewed here solved this problem by providing an interprofessional consultation team which was available to the direct service team (Grass & Umansky, 1971; Kahn, 1971). Several examples (Abrahms, 1969; Watt, 1973) describe an organization which had a policy team made up of representatives from the different disciplines to handle policy-level decisions affecting all the treatment teams. Others (Kovner & Seacat, 1969) describe a conscious effort to preserve the professional stimulation which is derived from professional departmental meetings and staff development, while protecting the integrity of the teams. The small size of the group which commented on these issues makes any systematic listing of how teams have handled it impossible. The lack of information on the subject suggests, perhaps, that this issue is not considered sufficiently by those concerned with interprofessional teamwork.

Leadership on the interprofessional team seems to be in a state of flux. The largest number of the teams in the study did have an assigned leader, but in many instances the designated leader served as a manager of the group process, allowing a number of team members to exercise leadership according to their abilities. The data suggest that the physicians and psychiatrists were less willing to follow this pattern of facilitative leadership. They tend to conduct teams which are more attentive to goals than group process and to retain the authority in their own hands. But leaderless teams do exist, teams with non-physician leaders exist, and some physician leaders are following new patterns of behavior.

## Implications for Social Work Role

The study showed social workers as the most frequently represented profession on the interprofessional team, although usually not in a leadership role. Social workers were generally performing casework functions with an emphasis on discharge or referral services and intake, admission or diagnostic services. When social workers served as team leader, they, in common with nurses, administrators and other leaders, tended to be less authoritarian, more process-oriented, and more oriented towards consensual decision-making and overlapping roles than were physician leaders.

Some specific examples did depict social work in an unaccustomed kind of role. Albini (1968) indicates that social workers can exercise their skills to recruit and retain a sample for trials of therapeutic modalities. Cowan and Sbarbaro (1972) discuss a program in which the social worker was responsible for assembling the necessary persons to compose an interprofessional health team on the basis of the needs of each patient who is served. In another example, a "medical-social" clinic (Cohen, Calligan & Ferrer, 1971) is organized in a general hospital for children with a high likelihood of psychosomatic disease. The social worker leads out with the first appointment and later introduces the doctor to the patient, a reversal of the more usual procedure.

Some of the changes in traditional social work role have come about because of manpower exigencies. Adamson (1969) describes a process which overcame a shortage of social workers by utilizing psychologists to perform the usual social history with the social worker acting as a consultant. In another restructured child guidance team (Chess & Lyman, 1969), the psychiatrist, psychologist and social worker abandoned their usual roles so that the team could respond instantly to requests for service from the busy pediatric clinics in a large metropolitan hospital. In treatment efforts which accelerate the process, social workers and other professionals adopt new techniques; a three-day hospitalization program for mental illness (Weisman, *et al.*, 1969) involves all professionals and paraprofessionals in intensive individual and group encounters with the patient during that brief period.

On many of the teams the social worker is somewhat of a generalist, serving direct functions with patients and also working in an educative or program planning capacity. One such example shows the social worker helping families relocate for employment (Abrams, 1968), another describes the social worker as a community organizer developing interest in and resources for stroke patients while working directly with those clients as well (Jivoff, 1971), and one article (Cowin, 1970) specifically discusses the generalist role of the social worker in a maternity and children's health service.

## Implications for Evaluation of Teamwork

Slightly more than half of the teams in the study did not report any evaluation procedure — a surprisingly high proportion in view of publisher's preferences for evaluative data. For the most part the group that did attempt to evaluate the team did so in terms of its effectiveness in achieving its goal. Very few teams examined

the efficiency of the model compared to some other mode of service delivery, and very few teams attempted in even a cursory way to assess the differential contribution of the various professions to the team effort.

Perhaps the effort to evaluate is impeded by the lack of clear purpose for many of the teams. According to the way the purpose was phrased in the articles under study, 23.1% of the teams did state a purpose which lent itself to measurement, while the rest were vague, general, and often all-encompassing. Presumably the objectives which were evaluated were more specific, yet the tendency to make broad assertions about team purpose which was noticed in this study must interfere with evaluation procedures.

Another speculation which could account for the sparsity of evaluative efforts is the effect that assessment might have on team processes. A climate of camaraderie, openness and trust is desirable for the team, yet a study of the unit's effectiveness might militate against such an atmosphere. This dilemma is especially real if the various professionals adhere to inflexible role definitions so they fail to perceive that operational changes are the desirable results of evaluation.

A significant increase in the tendency to evaluate was noted for the health field, compared to the mental health field and to the other fields as a group. Speculation does not yield a very satisfactory reason for this difference; perhaps the likelihood of a single and rather authoritarian leader in the health field facilitates evaluation and perhaps the outcomes are easier to measure than in mental health or the other fields.

### **General Implications**

An observation which emerged from the reports of team practice but which is not reflected in the numerical treatment of the data is the fact that professions are struggling with many of the same problems. All are concerned with defining an appropriate role, with utilizing and integrating paraprofessionals into their field, and with maintaining a flexible stance on the interprofessional team. All professions are contending with the dilemma of how to balance specialized and general skills. Occupational therapy, nursing, home economics, dietetics, rehabilitation counseling, and psychology struggle with these issues, and so, in fact, does medicine itself.

Another general comment concerns the diversity of team make-up. So many different professional combinations occurred that it almost seemed as though the particular professions included on a given team was more a matter of happenstance than careful planning and recruitment. It is rather alarming that the human services cannot be more prescriptive about the desired professional make-up of particular teams for particular purposes. Even in this rather small sample of 229 teams, 162 combinations were identified. Such diversity suggests that it would be impractical to prepare professionals specifically during their education for collaboration with all the professionals they might encounter, and that it may be more useful to equip the neophyte professional with general collaborative skills that may then be applied across the professional board.

Finally, the study revealed that accounts of interprofessional team practice are

prepared from many different perspectives and lack the consistency necessary to draw conclusions about the team processes which are successful in particular circumstances. Even those articles which emphasized the interprofessional team as the essential aspect of the service described often neglected to mention team leadership, decision-making, or communication patterns. Very few articles alluded to recording, although it is obvious that an effective, shared recording system could enormously facilitate the work of the team.

With very few additional words, these accounts of team work could have addressed issues in a way which would help other practitioners interpret the activity and decide whether the report is applicable to their own settings. Descriptive accounts of services rendered by interprofessional teams might routinely address the following questions:

- How was the size and makeup of the team determined? Are paraprofessionals included as regular team members?
- How was the leader selected? Did team members have input? Or is leadership role not designated?
- Is leadership exercised by a single individual, or more than one? Do different professions have their spheres of leadership?
- Is leadership focussed on goal attainment only or also on group processes?
- Are professional roles distinct or overlapping?
- How are decisions made? How are disagreements settled?
- What records are kept? Do all professions contribute to the same record?
- How can team morale be characterized? What data are available to reach conclusions about morale?
- How has the team been evaluated? Is the differential contribution of the various professions measured? If the team has been evaluated, how are the findings utilized?
- What affiliations do the various professionals maintain with professional counterparts outside the team? Do team members belong to a professional department within an organization as well as an interprofessional team?

Regular inclusion of material such as provided by the check list above would enormously enrich the descriptive accounts of team practice. Moreover, the accumulation of data would suggest variables which could be experimentally manipulated in order to determine more about what kind of teamwork works best.

## *Chapter V*

### **EVALUATING THE INTERPROFESSIONAL TEAM**

#### **RESISTANCES TO EVALUATION**

It is somewhat puzzling that the interprofessional team is such an entrenched modality and yet remains relatively untested. One can guess at the reasons for this situation.

Perhaps resistance to evaluation arises partly because interprofessional teams tend to function in contexts in which the effectiveness of the individual professions working alone is not yet established. Social workers, for example, have been hard pressed to defend the effectiveness of casework services (Mullen & Dumpson, 1972); in the absence of clear knowledge that casework itself is effective, the function of a caseworker on a team is unclear. The same point may be made about most of the professions which function on teams. Even the physician, most sacrosanct of the health professionals, cannot consistently point to a positive relationship between medical services rendered and health indicators (Donabedian, 1973). The accumulation of a group of individuals none of whose techniques are known to be effective singly complicates the evaluation of their combined team efforts. Early investigations of professional effectiveness, moreover, are more comfortably carried out in the privacy of one's own profession rather than in the full view of colleagues of other disciplines.

An additional problem in evaluation of the interprofessional team concerns the emotional and partisan climate in which teams tend to practice. The rehabilitation team, for example, functions within an ideology which strongly insists that the team can help the patient towards better physical, mental and social functioning. neither the professional team members nor the consumers of service usually wish to question such a belief. The planning team, again as an example, operates with the conviction that a rational, interdisciplinary approach to planning will produce sound blueprints for the future; such a belief is viewed by the participants, not as a testable hypothesis, but as an article of faith. By the time prevailing ideas about methodology for problem-solving have crystallized into well-established and well-funded team approaches, the original premises on which service is founded are likely to have become dogma. In order to facilitate the evaluation of correctional programs, therefore, one authority (Glaser, 1966) suggests that a belief in careful research and experimentation must be instilled in correctional personnel as part of their ideology.

Assessment is difficult to separate from the turmoil of an action program.

Evaluation often takes place in a highly politicized atmosphere in which program justification is a first priority to the administrator. Since operating budgets often depend on evidence that the team is achieving its goals, it is especially difficult to achieve a judicial evaluation of a large-scale program after resources have been committed to a massive effort. Glaser (1973) therefore, argues in favor of small in-house trials prior to launching a major new direction. For example, Community Mental Health Centers were funded in the belief that a concerted effort to rehabilitate patients and place them in the community would be effective. Once vast resources had been committed, what research group would readily report other than success in reaching the objectives? Failure to report success under such circumstances may lead not to careful changes but to far-reaching recriminations.

Resistances to research on the effectiveness of the interprofessional team, then, probably center around some well-founded fears over how negative findings might affect the team's future. In addition, the team member professionals may also dread negative findings about their own particular contribution. Resistances also come about because team members are often committed to an ideal that they accept as true. Research may then lead to unwarranted delays or, in the case of controlled studies, the withholding of seemingly helpful services. Added to these factors are all the difficulties in measuring a team's effectiveness which will be discussed in the following section. The research-resistant team can fairly safely claim that the results of research would likely be inconclusive anyway.

### EVALUATING THE INTERPROFESSIONAL TEAM

Interprofessional teams are complex entities which may be evaluated from different perspectives. They may be measured as to (1) their effectiveness in achieving their stated goals, (2) their efficiency in achieving goals compared to some other modality, (3) their appeal to clientele, and (4) their appeal to professional staff.

The would-be evaluator of the interprofessional team is faced with an exaggerated version of the problems posed by evaluative research in general. These issues, well-documented in many texts (Campbell & Stanley, 1966; Glaser, 1973; Weiss, 1972), include identifying appropriate comparison groups, minimizing bias arising from the study process itself, and choosing meaningful outcome criteria by which to judge success. The latter problem, if approached seriously, may produce an interprofessional battleground.

The puzzles in evaluating interprofessional teams can be summarized in some familiar interrogative terms, namely, when, who, how, and what. Given the caution with which one must apply the results of studies of teams, the cynic might also be inclined to ask "so what?" These questions will be discussed separately, beginning with the last issue raised.

#### **Applicability**

The various problems of evaluation research are compounded in efforts to assess the interprofessional team. Applications of study results must be made cautiously

and applied only to those teams utilizing a model similar to teams in the study. With the interprofessional team, almost an infinite number of teamwork models are possible since different professional members, operating procedures, group processes and external environments are combined in different ways. Interprofessional teams are also assembled for a great variety of purposes so that each model must be evaluated in terms of its effectiveness for achieving its particular objectives. To complicate matters even further, no uniform classification system exists to describe team models; terms such as "leadership," "decision-making," and so on are used with imprecision, meaning different things to different evaluators.

As if the diversity of team models were not enough, the individual team members also possess very different combinations of personality, interest, professional skill, experience, expertise, and motivation, as well as different latent qualities such as sex, age, and ethnic, racial and geographic background (Horwitz, 1970). Each team member brings his own distinct blend of professional and personal characteristics into interaction with each other member so that the number of possible combinations is staggering. It may be that each interprofessional team is so unique that findings about its effectiveness apply to that single team only.

The idiosyncratic nature of the team poses difficulties for determining the ideal professional make-up of a given team for a given purpose. A recent study (Kane, Jorgensen, & Pepper, 1975) attempted to assess the differential effectiveness of a nurse practitioner, a social worker, or a nurse practitioner-social worker team in meeting the needs of a nursing home population. In such an evaluation, the results are partially determined by the personal qualities of the particular nurse and social worker. A given nurse, moreover, may work very effectively with one social worker and not do so with another. It would hardly be feasible to extend such difficult experiments to include enough nurses and social workers to hope that the effect of individual attributes would level out. Random selection of professionals for assignment to teams is, of course, scarcely feasible in a free society. It is, therefore, highly possible that professionals who are attracted to a demonstration project with a rigorous research design are an atypical group who do not accurately reflect the professional populations from which they came.

Process studies which examine the satisfaction of team members with the interprofessional team are subject to the same difficulties of applicability. Grief and McDonald (1973) studied the attitudes of non-psychiatrist team leaders and team psychiatrists on three mental health teams which had that arrangement. This allowed a glimpse into an important issue in team leadership but unfortunately the results showed that one psychiatrist was satisfied, one moderately satisfied, and one dissatisfied; clearly these results could be due to individual differences in the persons involved.

The "so what" question is one which, indeed, must be applied to interpretation of reported results of team practice. Even if a team has been shown to be effective for a given purpose, the results may not warrant plunging ahead into establishment of a similar model. In each instance one must scrutinize the findings, decide how weighty the evidence seems to be, and, above all, whether a direct application can

be made to another context. This process of deciding whether evaluation results are relevant to other situations would be enormously enhanced by a more uniform language to describe interprofessional team processes and an orderly accumulation of research which builds upon previous research so that a systematic body of literature may begin to emerge.

### Timing

Another perplexing issue in the evaluation of the team is one of timing. Should a team be studied when it is brand new or when it has had time to develop a consistent pattern of operation? The latter certainly seems more desirable in many ways. It is, however, also important to plan evaluation early so that the necessary data are gathered and available when needed. A recent report on a team effort to work with child abuse situations makes this point (Barnes, Chabon, & Hertzberg, 1974):

From the beginning outside research consultants were obtained to evaluate team functioning and to develop research instruments to be adapted to the ongoing study of abusive families. Of particular interest are data that would enable the team to use differential treatment strategies with confidence, useful criteria by which potentially abusive families may be identified, and more precise figures relating cost to benefit. In comparison with other treatment programs, a distinct advantage has been the avoidance of methodological problems that are apparent in starting research late in program experience, leading to problems associated with meaningful research design as well as serious problems pertaining to retrieval of data [p. 605].

The authors have a persuasive argument here; a point that they allude to in passing but do not emphasize has to do with enabling the team to assess "differential treatment strategies." Ongoing research is needed to determine the best differential use of personnel among other things; one would hope that teams might change their mode of operating on the basis of these kinds of findings.

The timing of research is also related to the purity of design. It is methodologically sounder to study a team when it has a new caseload of clients. Otherwise the results of the study may be contaminated by the effects of previous methods of intervention other than the effects of the particular team process under study.

In fact, new teams are generally studied, if not in their first weeks of operation, then in the first few years of their existence. Little is known about those teams which cease being regarded as new departures in service and become everyday routine. Brieland (1973), addressing the hierarchical social work team, makes this point, which is equally relevant to the interprofessional team:

Much greater satisfaction may result from participating in a highly visible initial team than in affiliation with the twenty-third team in the agency after four years of operation [p. 51].

## Who Should be Involved?

The involvement of all professional disciplines within a team in forging criteria for evaluating the effectiveness of the operation could be painstakingly slow and cumbersome. Yet it is doubtful that a representative of a single profession can correctly pose the appropriate questions needed to assess the work of an interprofessional team.

Some years ago, Luszki (1958) pointed out that members of different academic disciplines engaged in team research have great difficulty reaching agreement on viable designs or even on what constitutes meaningful data. The sociologist, for example, may scorn the participant-observer approach of the anthropologist because of its sampling bias; the anthropologist may consider the survey technique of the sociologist to be superficial; and both may reject as invalid that date which the psychologist derives from projective tests. Members of interprofessional teams are usually less research-minded than their academic counterparts so that their different approaches to data may not be as readily apparent. Yet it is important to remember that members of different professions may employ quite different criteria for judging success.

An indicator of success to one professional may even be an adverse sign to another. The same behavior on the part of a student, for example, may be perceived as properly decorous to a teacher and unhealthily inhibited to a social worker or psychologist. The Clergyman on a mental health team considers spiritual peace as an important criterion of health, while this dimension may be ignored by other team members (Hiltner, 1957). Then, too, disagreements may arise about the proper time frame in which to judge success. The social worker's perspective usually calls for a lengthy follow-up period in the community before an ex-patient's progress can be evaluated. The lawyer in the juvenile court may be willing to measure the success of the endeavor on the basis of the outcome of the legal adjudication, whereas other team members may prefer to wait longer and add other factors. Some professionals place more credence than others in the client's own statement regarding the degree to which he was helped by the team; others may place faith in a projective test; still others will accept neither of these sources of data.

The evaluation procedure would be simplified (and the team also would function more smoothly) if such questions around outcome were debated at the beginning of a team's life. At the time when the team is struggling to define its goals and to bring all professional perspectives together in that effort, focus on concrete indicators of success rather than on acceptable generalities would bring differences of philosophy into the open and make a genuinely interprofessional solution possible. The evaluator's burden would be lightened if the team's goals and the team member's division of labor did indeed reflect the joint thinking of all its professional members.

Team members of various professions must be involved in developing criteria to assess the competence of the various member professionals on the team and the effectiveness of each contribution. In a very sophisticated study to evaluate the effectiveness of interdisciplinary teams for diagnosis and treatment of retardation in

rural areas (Grass & Umansky, 1971), subjective standards were used to evaluate professional performance. In this example the Child Development Clinic (CDC) in Oakland was evaluating three clinics it had established in outlying areas: to evaluate the performance of the physicians, psychologists, nurses and social workers involved, the CDC counterpart of the particular profession made the judgment on the basis of standards integral to that profession. A composite score for each clinic was then derived from the average of the individual ratings of the professionals on the teams.

Hopefully, a case has been made for all team members to have a voice in the evaluation planning. It is by no means certain, however, that the team should be responsible for the actual conduct of the evaluation. At best team members are more interested in action than in careful research, and, at worst, the team could be caught in a conflict of interests over reporting results (Weiss, 1972). An independent arm of the same agency may be less biased but, on the other hand, may have a strong investment in preserving the status quo. An outside evaluator, must, however, have the benefit of the team's thinking lest his efforts prove sterile and unrelated to the real goals and activities of the team.

### **Focusing Studies of Teams**

Any attempt to evaluate interprofessional team work requires decisions about what questions to ask and where to begin. Some studies of teams have attempted to assess the satisfaction of team members and/or the satisfaction of consumers of service. It is not clear, however, that either of these measures provide accurate indications of the team's effectiveness in meeting its own objectives. It is possible to measure team success in terms of concrete, though rather crude, criteria such as rehospitalization rates, recidivism, or school grades. Yet without any linkages of outcome to various team processes, the information yielded is not immediately helpful to anyone planning a new interprofessional team.

Team morale, usually measured by satisfaction of team members, is a perplexing issue. It would seem logical that a team torn by tensions, and characterized by depressed or angry personnel could hardly function at its maximum level. Yet, some evidence suggests that a high level of team member satisfaction might indicate that comfortable non-threatening norms had been established rather than that the team was pursuing its objectives (Bass, 1960; Anderson & Carlson, 1971). Figures on team member satisfaction, moreover, are usually not monolithic; generally some professions will express high satisfaction and others express dissatisfaction. A final dilemma is how to collect information about team member morale. One can hardly be certain that polling team members will yield valid data, especially if the members are still employed. Unobtrusive measurements such as absenteeism or length of employment might be sought, yet absenteeism and employee turnover are obviously related to other issues besides job satisfaction. Studies that have examined team member satisfaction (Banta & Fox, 1972; Silver, 1974) relied on interviews of the team members rather than developing an unobtrusive measurement.

Consumer satisfaction is no less complicated a phenomenon. It may be measured by client ratings of the team as a whole or of its separate professional components. It is questionable, however, whether the client should be expected to respond with a separate rating on each team member; some team members may be providing important but inconspicuous services which could be contributing to the overall satisfaction of the recipient. The relationship of consumer satisfaction to effective practice is also unclear. The popularity of "quacks" on the health scene is an obvious commentary on the validity of consumer satisfaction as a sole evidence of provider effectiveness. Another example is found in a study which showed that deliberately absurd and erroneous lectures may be highly rated by student audiences (Naftulin, Ware, & Donnelly, 1973). Client satisfaction is in itself, of course, a highly desirable commodity and one for which humane professions are ethically bound to strive. Measurements of consumer opinion, therefore, continue to be important and necessary, yet cannot be used as a single basis for claims of effectiveness.

Effectiveness of the interprofessional team must be measured against some objective criteria related to that team's goals. Sometimes the goal of service includes satisfying the consumer so that he will utilize the services. A pediatric team approach to outpatient services in a low-income, Spanish-speaking neighborhood (Yedwab & Schmidt) employed a house-to-house evaluation with Spanish-speaking interviewers in order to determine opinion about their services. The finding that 70% of those sampled considered the program their primary source of care and that most could recall their doctor's name suggested that the team was fulfilling its goal of providing continuous and personalized health service.

In searching for appropriate measures of outcome, it is helpful to distinguish between effectiveness, efficiency, and efficacy. Using Community Mental Health teams again as an example, let us suppose a team goal is placement of mental hospital patients into the community. The effectiveness of the program can be measured in terms of the number and quality of community placements made. Efficiency concerns the amount of resources (in time and money) that are expended to achieve a goal; a program cannot therefore be considered efficient unless it is also effective. If the mental health center processed 500 patients daily and made few placements, it would not be efficient despite its brisk activity. Efficacy is perhaps the most difficult of this triad of terms; it refers to the appropriateness of the original goal. Despite an impressive record in placing patients in the community, a mental health center might later discover that these patients were less stimulated and more regressed than they had been in the hospital. In terms of mental well-being, the goal could not then be viewed as efficacious no matter how effective or efficient the team had been in carrying it out.

### **Examples of Team Evaluation**

Every team, just as every solo practitioner, should be accountable for whether it achieves its objectives. At the very least, statistics of success or failure are needed, although some reports of team endeavors, especially prior to this age of

accountability, lack even this much attempt to document their effectiveness. When a team is being considered, moreover, it is insufficient to show the effectiveness of one member only. It has been promulgated as a principle for monitoring health care (Morehead, 1970) that fine medical care alone is not enough for a positive evaluation, but the team's physicians and specialists and ancillary professions must be available and efforts to alleviate social and medical problems must be coordinated.

Besides documenting the outcomes of the project in some basic statistical way, it is useful to show that the team is more effective than no service or service through regular, non-team channels. Such an effort involves the quest for the control group. In a study of a team effort to resocialize mental patients (Brandon & Jackson, 1961), a pool of patients were randomly selected for the project or returned to the regular ward for the control. The authors indicate that hospital personnel found this randomizing procedure hard to accept. In the health field, matched controls are sometimes used as, for example, in Silver's ambitious controlled evaluation of 100 families receiving health team services. Both controls and experimental group were followed over a five year period with before and after measurement taken on health and mental health indicators (1974). A similar project in community psychiatry with matched controls was sponsored by Menninger Foundation (Taylor, 1970). A recent study examining the effectiveness of a nursing home placement team sent an interdisciplinary team of judges to the home shortly after the placement was made to evaluate the placement's appropriateness in comparison to another placement to the home which was not made by the team (Williams, Hill, Fairbank, & Knox, 1973). In this ingenious evaluation, the research team was blind as to which placement was made by the experimental group.

These approaches obviously require investment of time, personnel, and money. Sometimes comparisons may be derived from regular sources. In a recent study of team effectiveness in nursing home care (Kane, *et al.*, 1974), state health department data on disability were used as a control. At times no control is available and a time-series approach must be used (Campbell & Stanley, 1966). An example of this is a study of a multidisciplinary approach to an elderly welfare client population in a single-room occupancy hotel (Plutchik, McCarthy, Hall, & Silvenberg, 1973); since no reasonable comparison group could be located, repeated measurements of the population were taken over time.

Controlled studies of effectiveness are rare and must be applauded. Yet the interprofessional team is usually such a multifaceted entity that some linkage of result to process is also important. Without these data, it is difficult to state which team efforts of which team members contributed to the success or to distinguish those processes positively associated with outcome from those negatively related to the result. Perhaps, for instance, one profession could be eliminated entirely from a particular team with a savings in cost and no detrimental effect on outcome. The enormous number of possible combinations of personal, professional, and process variables that constitute the interprofessional team make these choices about what to study extremely difficult.

In studying the team, a balance must be struck between process observations and

outcome measurements. It is possible through an anthropological approach as participant-observer (Eichhorn, 1973) or through detailed diaries and soul-searching on the part of the participants (Taylor, 1970) to amass voluminous information about the interaction and reactions of team members. Perhaps in the long run such detail is less helpful than planned collection of a few specific process measures which are linked to specific questions about outcome.

The problem of what to study is simplified if a new member has been added to a team which already has baseline data about the effectiveness of service, or if one new procedure is instituted in an already functioning team. It is easier to measure the effectiveness of an addition in service or the effect of a subtraction, than to gauge the impact of an entire interprofessional program (Glaser, 1973). An example from a school setting is a study (Grill & Himmelman, 1959) which examined the effectiveness of the addition of a social worker to an experimental school program to work with children with emotional blocks to learning. Parent satisfaction, teacher satisfaction and pupil progress were all measured, providing some indications of whether the social worker was a useful addition to the team.

Usually the item to be measured is not well-defined and the evaluator is forced to consider an enormous number of possible variables. If he decides to limit his study, he risks ambiguous results. Heyman (1965), for example, studied the relationship between initial agreement of physician, social worker and patient on the nature of the socio-medical problem and its desirable solution to the ultimate outcome of the case. Thus she probed a key question about the association between team agreement on goals and positive end-result. Yet the inquiry left out so many factors that it had to be inconclusive. It is a long leap from initial agreement of two team members on problem and solution to the ultimate conclusion of the case. (Parenthetically, this research also illustrates the problem of professional isolation in studies of interprofessional matters; the agreement of the doctor and social worker was determined on the basis of a social worker's rating of that initial agreement.) Another example of the difficulties in choice of variables is found in a study of the effectiveness of a comprehensive health program for children of low income families living in a housing project. Another project served as a control, but outcome was indicated by rate of absenteeism from school. Since absenteeism reflects more than health factors, and since it might be assumed that the same parents who valued health care also valued school attendance, the positive results must be carefully interpreted (Kaplan, Lave & Leinhardt, 1972).

A possible solution to the impossibility of studying all things at the same time is repeated studies of different aspects of the same team. This approach also is imperfect since team members usually turn over at a fairly rapid rate, client problems change, and even the team purpose may shift consciously over time. In this sense the team may be a different instrument from its former self at an earlier point in time. Evaluation of an interprofessional team differs radically from the controlled laboratory studies from which much of our current knowledge about group process stems.

### **Efficiency**

In addition to studying effectiveness in achieving goals, the efficiency of the

team should also be considered. Does the team achieve the goal with less expenditure of resources than would all professionals working alone with intermittent, episodic contacts on an individually-initiated basis? Or, if the team is obviously costly in terms of personnel and time, can it be demonstrated that the interaction of the various members has produced an effect which could not have been achieved without the team organization.

How to measure the meshing effect of the team is an issue. Unlike the chemical reaction, professional ingredients to the team are not constant qualities and the reactions cannot be predicted with any accuracy. As we understand more about team effectiveness, however, we may be in a better position to describe efficiency. Once it can be stated with some certainty that Professionals A, B, and C working under conditions X, Y, and Z tend to produce a desired outcome, we can then test whether the same result could have been produced as effectively and less expensively in a non-team context.

The team's efficiency need not be compared only to the non-team; various internal team arrangements may be compared to determine their cost effectiveness. This was attempted in the above-cited nursing home project (Kane, *et al.*, 1974) which tested several alternative models of care. It was done in a prepaid group practice (Sloss, Young, & Weinerman, 1968) which attempted to evaluate the effect of adding free services of a team of physicians, nurse, social worker and health educator to the practice; the cost of these preventive services were carefully documented. In another study of the health team (Beloff & Karper, 1972), the work of each member, including physician, social worker, nurse, dietitian, and health aide was carefully monitored to determine how frequently each of these disciplines initiated contact, were requested by patients, and what kinds of services each rendered. Such a study paves the way for differential use of personnel on a cost-effective basis.

The current vogue for role-blurring, especially on psychiatric teams, does hamper efforts to determine the relative cost-effectiveness of different combinations. At the same time, the policy of designating tasks to team members without regard for their professional preparations raises the question of whether teams could be as effective and much more efficient if they were composed of the least expensive personnel.

#### SUMMARY

In summary, then, all evaluation research is difficult, and evaluation of the interprofessional team is especially fraught with methodological problems. Difficulties specific to the evaluation of the team include consideration of which professions should have input, who should actually conduct the evaluation, when in the life of the team the evaluation should take place, what variables should be measured, and how the numerous combinations of professional, personal, and process dimensions can be managed in a single study. Assessing the efficiency of an interprofessional team also poses problems which involve finding ways to separate the contributions of the various members.

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