Teams and Team Effectiveness in Health Services Organizations

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CHAPTER OUTLINE

• Introduction
• Types of Teams in Health Care
• A Typology of Teams in Health Care
• Understanding Team Performance
• A Model of Team Effectiveness
• Conclusions

LEARNING OBJECTIVES

After completing this chapter, the reader should be able to:

1. Describe the role and value of teams in health care organizations
2. Distinguish among different types of teams in health care organizations and how these differences affect team processes and performance
3. Understand the factors associated with high-performing teams
4. Describe the potential impact of team characteristics, nature of the work, environmental context, and team processes on team performance
5. Explain alternative methods of decision making in teams, including both functional and dysfunctional decision-making processes
6. Describe the importance of psychological safety to effective team decision making and performance
7. Discuss how factors external to the team may affect team processes and performance
8. Understand the multiple impacts of team cohesiveness on team performance
9. Describe key aspects of group process including leadership, the communication structure, decision making, and stages of team development
KEY TERMS

Accountabilities in Teams  Psychological Safety
Ambassador Activities  Reciprocal Interdependence
Behavior Norms  Sequential Interdependence
Boundary Permeability  Scout Activities
Boundary-Spanning Roles  Skill-Based Pay
Communication Networks  Social Capital
Communication Technology  Social Loafing
Decisional Authority  Stages of Team Development
Delphi Technique  Status Differences
Diversity  Support Teams
Environmental Context  Task Coordinator Activities
Formal Leadership  Task Interdependence
Formal Groups  Team-Based Rewards
Free Rider  Team Cohesiveness
Groupthink  Team Composition
Informal Leadership  Team Goals
Informal Groups  Team Interdependence
Intergroup Relationships  Team Leadership
Management Teams  Team Learning
Membership Fluidity  Team Norms
Nominal Group Technique  Team Performance
Organizational Culture  Team Processes
Parallel Teams  Team Size
Performance Norms  Temporal Nature of Teams
Project Teams  Tenure Diversity
Pooled Interdependence  Work Teams

IN PRACTICE: Improving Preventive Services in a Pediatrics Practice: A Less-Than-Successful Team

Glendale Pediatrics is a nine-clinician pediatric group practice. The practice serves a largely middle-class suburban population and prides itself on the provision of preventive services. One of the physicians recently attended a continuing medical education program on preventive services. Upon her return, she decided to assess the practice’s performance in this area. She and the other physicians were surprised when she distributed the results. Among the findings were:

- Sixty percent of children were behind schedule in at least one immunization
- Vision screening was conducted and recorded for only 15 percent of children
IN PRACTICE: Improving Preventive Services in a Pediatrics Practice: A Less-Than-Successful Team (Continued)

• Fifty percent of children were screened for anemia
• Twenty-five percent of children had their blood pressure recorded in the patient record
• Thirteen percent of children were screened for lead

While the pediatricians were bewildered by these findings, the medical record and nursing staff found them consistent with their impressions. The findings were presented and discussed at the monthly staff meeting. Two physicians who together saw about 40 percent of all patients were adamant that their patients were current in their preventive services, and there was no need for a practice-wide effort to improve their preventive service rates. Unfortunately, the data were not linked to individual physicians and thus there was no way to verify their claim. Nonetheless, it was agreed that staff, including the two reluctant physicians, work as a team to address the problem.

The first meeting was scheduled over the noon hour. One of the physicians arrived at 12:20 while two others left early, at 12:45. One of the nurses was out sick. No decisions were made, and the entire meeting was spent attempting to find a date and time for follow-up meetings.

At the next meeting, one physician stated that during an acute visit, physicians do not have time to go through the medical record to determine if a patient was behind on any preventive services. The other physicians agreed and decided that a form should be developed listing all preventive services, and this should be attached to the medical record. The nurses worked together after the meeting to design the form, known as the Preventive Services Chart (PSC).

Three thousand copies of the PSC were printed. When the physicians saw the form, they indicated that it was poorly designed. All relevant services and immunization schedules were not included. The forms were destroyed, and the physicians asked the nurses to redesign the form. The nurses consulted with the physician who attended the continuing education seminar to obtain information on the recommended preventive protocols. Based on this information, the form was redesigned with the immunization schedule and other information added. Confident that this was the right form, 3,000 copies were again printed. When presented to the physicians, it was discovered that there was little agreement among the physicians and an argument broke out at the next meeting about the immunization schedules and protocols for screening.

After this meeting, one of the nurses in consultation with two physicians developed yet another form with separate columns for each physician’s preventive services preferred protocol. The medical records staff, hearing about this new procedure informally over lunch, was skeptical about its feasibility. Moreover, when one of the nurses asked a physician when nurses would record this information, she was told that “nurses have it too easy in this practice ... you have a great deal of down time and you certainly can find time to prepare charts for the next day’s patients.”

During the next three weeks, the following events transpired:

1. Nurses complained to the physicians that medical records staff were not making records available to them in time to do the preventive services review.
2. Medical records staff complained to the physicians that nurses were unrealistically requesting the next day’s charts at 9:00 a.m. so they could spend the day preparing for the next day’s patients. They also reported that nurses were rude in their requests.
3. Physicians complained among themselves that preventive services information was absent for almost half of the patients, and they suspected that the information was inaccurate for a significant number of cases for which information was provided.
4. Nurses were spending an additional 1–2 hours in the office preparing the next day’s files. They complained that the medical records were very hard to decipher. They requested, and were denied, overtime pay.
CHAPTER PURPOSE

Teams represent the bedrock of health care organizations, whether we are talking about delivering clinical care or preventive care services, teaching health professionals, or conducting all manner of clinical and health services research. The effectiveness of teams can have a direct impact on the effectiveness of the entire organization. A highly skilled professional may be unable to apply her training and skills without an effective team to support her work. Similar to the need to manage information, financial resources, and people, teams also need to be managed. They rarely function to their full potential without appropriate leadership. The purpose of this chapter is to help managers to draw on the full potential without appropriate leadership. The purpose of this chapter is to help managers to draw on the full potential of teams and to overcome the most common obstacles to optimal team performance. The chapter presents evidence about team effectiveness and team management strategies that may be applied by managers to strengthen their competency in managing and improving teams.

INTRODUCTION

The Glendale Pediatrics case illustrates the variety of ways that teams can run into difficulty. Nonetheless, teams are a mainstay of life in health care, and can be useful vehicles for improving quality—if they are organized and managed in an effective manner.

The use of teams is common in organizations, and this is particularly true in health care. In fact, teams represent the dominant way that work gets done in organizations. When working effectively, teams have the potential to improve organizational effectiveness while also having a positive impact on morale, job satisfaction, and commitment to the organization. The key, of course, is that teams need to be highly functional for us to reap the rewards that teams potentially bring. When teams suffer from dysfunctional processes or work relationships, productivity and effectiveness can be seriously jeopardized.

The use of teams in health care is no longer an option; teams and teamwork are a necessity. Clinical and management work both require teams, although there are many different types of teams. Work is simply too complex for it to be dependent on a single individual. The model for innovation and invention is no longer the solo scientist; the Thomas Edison model of innovation is long gone. One need only look at articles in such medical journals as the New England Journal of Medicine or the Journal of the American Medical Association (JAMA) to understand that advances in medicine are made and reported by teams. Furthermore, the composition of teams is usually multidisciplinary because innovation is dependent upon people with multiple skill sets. Successfully sending a man to the moon was the work of an effective team, while the Challenger disaster was, in part, due to a team with multiple communication and coordination problems.

In the clinical realm, effective patient care and management are dependent upon teams. This is the case whether we are dealing with a patient undergoing a surgical procedure in an operating room or a frail elderly person with multiple chronic medical conditions living at home. In clinical situations, teams are required to not only provide effective medical solutions but also recognize and take action to solve problems that may

IN PRACTICE: Improving Preventive Services in a Pediatrics Practice: A Less-Than-Successful Team (Continued)

5. Confusion was rampant when files were prepared for one physician, but another physician ended up seeing the patient. An even more difficult problem was caused by drop-in patients, for whom record reviews were not prepared. Nurses spent up to 30 minutes looking over these drop-in charts and recording the information on the PSC.

6. Two weeks after the system was implemented, one nurse quit abruptly at 3:00 and walked out.

7. One physician gave each parent the PSC and asked parents to record preventive services themselves since the physicians were "too busy to keep track of this."

After a month, the team met again. The physicians decided that the "solution" caused more problems than it solved. They decided to disband the team and work on the preventive services problem individually.
lead to medical errors. In fact, the entire quality improvement movement—whether in automobile manufacturing or hospital infection control—is dependent upon teams. Team training and effective team management are central to quality improvement initiatives. In reality, there are few, if any, individual heroes or heroines in organizations saving the day. In fact, even the most gifted and talented people need a supportive team to sustain their performance. In most situations in health care, the organization will not reap the full benefits of a talented person unless he or she is supported by, or part of, a strong, competent, highly functional team.

The goal of this chapter is to improve the reader’s understanding of what makes teams effective. To do this, we provide background on the many types of teams that exist in health care, how teams differ in their functions and processes, the common pathologies facing teams, and strategies for improving team performance. We note as well that with globalization and advances in technology and communication there have come new approaches to team organization, such as the use of virtual teams in which team members may never actually have face-to-face contact. For example, the authors of this chapter rarely interact in person; our collaboration is mediated by information technology. The use of virtual teams challenges organizations to develop new ways to manage such teams.

For many decades, teams have been the focus of extensive research; therefore, much has been learned about team effectiveness. Some of this research has been conducted in health care organizations, but the vast majority has been carried out in other settings, ranging from sports teams to product development teams to airline pilot crews. A remarkable aspect of this research is that lessons learned from one type of team are often applicable to other types of teams. This provides the opportunity to use the results of research carried out in diverse settings to inform this discussion of teams in health care. Thus, this chapter will present some of the most important research findings related to high-performing teams. The discussion will begin with a description of the types of teams found in health care organizations.

**TYPES OF TEAMS IN HEALTH CARE**

Teams are groups, but not all groups are teams. Teams have a defined purpose, membership or composition, structure, specific processes, and leadership. Groups (that are not teams) may possess some characteristics of teams, but lack one or more key elements. A basketball team is, of course, a team. It has a purpose, defined members (composition), structure (team members are assigned positions and have roles), processes (how the team will work together), and formal leaders (captain and coaches). Often there are informal leaders as well. A surgical team clearly meets the characteristics of a team; it has a purpose, defined members, structure, processes, and leadership. However, one surgeon on the team may have more influence on team members than the second surgeon—even with all factors being equal. A group of nurses who go out to dinner together would likely not be a team, although meeting some of the characteristics of a team. While we can quibble about what is and what is not a team, our focus in this chapter is on work teams in health care organizations whose purpose is directly related to the goals of the organization. While this definition may seem narrow, we will show that even within this definition, there is a very wide range of teams in health care that differ along many different dimensions.

First, it is important to acknowledge that although not all groups are teams, groups that are not teams can have a substantial influence in an organization, often wielding considerable power. The importance of informal work groups and group processes has been recognized for at least 50 years. The Hawthorne experiments firmly established the proposition that an individual’s performance is determined, in large part, by informal relationship patterns that emerge within work groups (Roethlisberger and Dickson, 1939). The work group has a pervasive impact on individual behaviors and attitudes because it controls so many of the stimuli to which the individual is exposed in performing organizational tasks (Hasenfeld, 1983). Thus, in addition to formally sanctioned teams, we need to be aware of informal groups and their influence on the organization. Some discussion of informal groups is therefore warranted.

**Informal Groups**

Informal groups are those that are not formally established or sanctioned by the organization, but often form naturally by individuals in the organization to fill a personal or social interest or need. Informal groups can have high motivational value for individuals. A group of employees in different parts of an organization may serve a number of functions, such as social support and sharing of information. Such groups may be viewed positively by the organization because they may improve morale and communication in the organization. For example, an informal group of administrative support...
Informal groups can also have a negative impact on an organization. Groups may become overly exclusionary and lead to interpersonal conflict. In some instances, informal groups can become so powerful so as to undermine the formal authority structure of the organization. Consider Etzioni's (1961) classic description of the role of informal groups in factories:

The workers constituted a cohesive group which had a well developed normative system of its own. The norms specified, among other things, that a worker was not to work too hard, lest he become a “rate-buster”; nor was he to work too slowly, lest he become a “chiseler” who exploited the group (part of the wages were based on group performance). Under no condition was he to inform or “squeal.” By means of informal social control, the group was able to direct the pace of work, the amount of daily and weekly production, the amount of work stoppage, and allocation of work among members. In this instance, informal groups of employees were able to maintain social control as well as control over the pace of work through the imposition of informal, though well enforced, rules of behavior.

Informal groups can also assume a change agent role. Such groups may initiate changes to improve working conditions and, as such, may evolve into formally sanctioned groups. In addition, informal groups may emerge to deal with a particular organizational problem or to work toward changes in organizational policies and procedures. Such groups may, in fact, initiate action against a corrupt manager or supervisor.

In sum, informal groups can play an important role in organizations. However, it is important that managers be aware of the existence of informal groups in the organization and the roles they play, whether positive or negative.

**Formal Groups**

In the remainder of this chapter, we focus almost exclusively on teams in health care organizations. That is, the focus is limited to formal groups, or teams that are formally recognized, organizationally based, social systems. Extending the earlier definition, we view teams as intact social systems with boundaries, interdependence among members, and differentiated member roles or structure. Organizationally based teams are task-oriented with a specific purpose. They generally have one or more tasks to perform and produce measurable outcomes. Finally, they operate within an organizational context and interact with a larger organization or organizational subunits (Hackman, 1990a). This approach is consistent with the following definitions:

A group is defined as two or more persons who are interacting with one another in such a manner that each person influences and is influenced by each other person (Shaw, 1976).

A team is a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems, and who manage their relationships across organizational boundaries (Cohen & Bailey, 1997).

We include in our discussion teams that are time-limited, such as project or product development teams, as well as those that are more permanent in nature. It is important to note that in addition to the permanence dimension, teams vary across many other dimensions as well. The most important of these are discussed below.

**IN PRACTICE: Can We Create a Team Culture?**

As Chair of a subspecialty department in a medical school, Dr. Rideout understands that patients are treated not just by individual physicians, but by teams of people in the department. For example, when a patient enters the clinic, she confronts a team of individuals—a desk clerk, nurse, technician, physician, a patient business associate, and so forth. He has found, however, that these teams have dysfunctional characteristics and result in low levels of patient satisfaction and poor morale. He has consulted with his staff and is struggling to create a department that is supportive of teamwork. Consider the following comments:

**From a Physician:** “They’re typical state employees. When I need a technician to prep a patient in the clinic, they’re nowhere to be found. What do these people do all day? It’s my job to treat patients, and since we’re now paid partially on the basis of patient satisfaction scores, when a patient is left waiting, this brings down our scores and we all suffer. These state employees
From a Technician: “Many of these physicians treat the clinic as if it is their private practice. They think that all they have to do is snap their fingers and a technician will magically appear. Never mind that each technician works for three or four physicians and, when a physician needs me to prep a patient, I am usually in the process of prepping another patient for someone else. The physicians are worried about patient waiting time. Most of them show up around 8:45 in the morning for their 8:00 appointment, so we’re already behind schedule by 8:01. Then they disappear midday without telling us where they are or when they’ll be back. And they’re blaming us for our dismally low patient satisfaction scores.”

From a Patient Business Associate: “This is a difficult job. I do everything from answering phones, registering new patients, dealing with payment and insurance issues with patients, communicating with patients in person and by phone, and solving or trying to solve problems. When a patient is angry, it’s my job to diffuse her anger. When a physician gets angry with me or someone else, I grin and bear it. The worst situation is when physicians argue with staff in front of patients. We provide excellent quality care, but patients do have other options. We need to think of the patient in customer terms. My days are filled with multitasking and being accountable to physicians and the clinic directors—and also advocating for patients. I must be focused, attentive to details and friendly. This is a stressful and unpleasant place to work. I’ve been here five years, and last week I started sending my resume out.”

From the Clinic Director: “I am caught right smack in the middle. Everyone complains to me. The technicians complain about the physicians and schedulers, the patient business associates complain about the physicians, and they probably all complain about me. My co-director and I have worked hard to get some team spirit around here. We have social events on holidays and birthdays, but only the Chair and one or two physicians ever attend. As I see it, everyone here has turned into a caricature. Physicians and staff don’t speak to each other as individuals, but as stereotypes. ‘Technicians are lazy, schedulers are incompetent, patient business associates are do-gooders who try to get patients seen even if they can’t pay, and physicians are arrogant.’ The only thing positive here is the Chair. Everyone likes Dr. Rideout, but he doesn’t like confrontation and has let things go too far. He should have been stronger and gotten these people into line long ago. We’re a teaching hospital, and these people behave like they’re 6-year old brats. I love the mission of this hospital, but I could get a job in a private medical practice for better pay and far less stress.”

As the chair of the department in a Midwestern medical school, Dr. Rideout realizes that this situation has gone from bad to worse. The department is among the lowest in the health system in patient satisfaction scores, and staff morale is at its lowest point in the 10 years that he has been chair. “Our employees are loyal, but we scare away many good potential employees. On several occasions, new staff members have left after two weeks here.”

Dr. Rideout is a firm believer in teamwork, but he has become exceedingly frustrated because of deterioration in whatever teamwork there may once have been. This was a tough place when he came 10 years ago and has not improved. He is skeptical of all of the complaining, and thinks they are all to blame—or no one is to blame. He is a good listener, and has hoped that his listening will diffuse the anger felt by physicians and staff. This has not worked. He is planning on retiring in two years and wants to leave the department in better shape than it was when he arrived.

Dr. Rideout is sincere and well meaning, but does not know where to turn. He feels he is dealing with some very difficult personalities, and perhaps this is just the way of the world. Dr. Rideout has consulted with other department heads, his wife, a psychiatrist, and with his clinic directors. He has even spoken with his minister. These people were kind and supportive, but could provide no real help. However, at the Christmas party two weeks ago, he happened to be talking with a student working on her MHA. Being in the holiday mood, he shared some of his problems with her. She had some interesting comments and observations. Most memorable were two specific comments: The first was: “Many health care organizations are filled with good people working in bad processes.” The other comment, which really caught his attention, was: “Every system is perfectly designed to achieve the results that it produces.”
A TYPOLOGY OF TEAMS IN HEALTH CARE

A discussion of team characteristics can be confusing because of the multiple ways teams have been described over time. Using a typology (i.e., grouping by dimensions) generally facilitates this type of discussion; therefore, in this chapter, we use the subsequent typology along with a description of each element:

1. Function or purpose
2. Decisional authority
3. Temporal nature
4. Time and space
5. Diversity
6. Accountabilities
7. Membership fluidity and boundary permeability

Function or Purpose: Why a Team?

The first element in our typology is function or purpose. Teams are used for multiple purposes in health care and have become the norm for getting work done. An important question worthy of attention is whether it is desirable to have a team, rather than an individual, accomplish a particular task. In many settings, it is routine for a manager, faced with a difficult decision, to assign a team to analyze the options and make a recommendation. That is, if a complex task is to be accomplished, a team is the most appropriate vehicle for accomplishing the work. It is not an exaggeration to say that teams are the building blocks of organizations.

There are many potential advantages to teamwork. Assuming that teams are functioning effectively, they have the potential to create synergy among its members—when the productivity of a team exceeds that of the sum of individual members. This is because innovation can result from the interplay of ideas among team members, especially when members build on and critically evaluate the work and ideas of others on the team during the decision-making process. In this way, if one member of a team misses an important factor, other members can supplement such gaps with the information necessary to make an effective decision. In addition, teams can be a source of empowerment and satisfaction for employees, which, in turn, may lead to lower turnover and absenteeism, and greater commitment to the goals of the organization. Perhaps of greatest importance is that teams bring together diverse expertise and perspectives from multiple disciplines (Galbraith, 1977; Kanter, 1988). As a result, this knowledge is brought to bear on a particular problem, decision, or task.

This chapter focuses on the use of teams and emphasizes their advantages; however, it is also important to note that drawbacks exist, and managers should exercise caution in the use of teams. For example, instances exist where the use of teams may diffuse talent in an organization. Is the organization asking its most talented people to spend time on a team when their time could be better spent addressing important organizational concerns? Teams also require a level of infrastructure and processes to function effectively. Is an organization that is not team-focused prepared to make the infrastructure and process changes required for team performance? For example, most organizations are organized under traditional unity of command principles. That is, each person is accountable to one person. However, when an organization moves to cross-functional teams, employees may have multiple accountabilities, perhaps to a project team manager as well as their functional manager. As a result, the organization must be prepared to train managers to supervise teams, while also training employees to work in a team-focused environment. Following from this, individuals within the organization must have team leadership skills pertaining to conflict resolution, overcoming communication obstacles, and effective structure techniques, among other issues facing teams. Although teams have the capability to boost productivity and improve quality, they also have the potential to increase costs and stress if they are initiated in an organization unprepared to meet the challenges of working with teams.

In determining if the use of a team is appropriate for a particular task or decision, it is important to understand the multiple purposes of teams. We describe work teams, support teams, parallel teams, project teams, and management teams in the following paragraphs.

Work teams are groups of people responsible for producing goods or providing services. These teams are directed at the primary mission and objectives of the organization: treating emergency department patients, providing immunizations and other preventive services to children, and developing a new pharmaceutical product, among others. These teams may be directed by supervisors or manage themselves. In the health care environment, work teams include treatment teams, research teams, home care teams, and community-based crisis intervention teams. Work teams are usually ongoing
and relatively permanent in nature, although membership and leadership of these teams may vary. Work teams can consist of members of the same discipline, or they can be multidisciplinary. They may also involve people at multiple levels in the organization, and people with significantly different levels of education. Some people have used the term “microsystems” to describe small groups of people who work together on a regular basis to provide care to patient subpopulations (Nelson, et al., 2002). These are freestanding clinic units with both clinical and business aims designed to maximize performance outcomes (Batalden, et al., 2003). We can say that work teams do the fundamental work of the organization, whether this means providing services, producing a product, or producing knowledge.

Other types of teams provide support for the primary functions of the organization. Such support teams enable others to do their work, and serve many functions such as quality improvement, strategic planning, and search committees hiring new employees. Note that individuals who serve on work teams may also have a role on support teams. In this situation, they are referred to as parallel teams—teams typically composed of people from different work units or jobs who carry out functions not regularly performed in the organization. They usually have limited authority and generally make recommendations to individuals higher up in the hierarchy. Parallel teams include quality improvement teams, employee involvement groups, and task forces. In the health care system, parallel teams may be involved in such activities as continuous quality improvement (CQI) and process improvement, community health needs assessments, and staff search committees. By their nature, they are often multidisciplinary. As suggested by the diversity of teams falling into this category, these teams may be temporary or permanent features of the organization.

Project teams are usually time limited, producing one-time outputs such as a new product or service or a new information system. In health care, such teams may exist for purposes of planning a new hospital, developing a new Alzheimer’s drug, writing a new employee handbook, or developing a hospital disaster preparedness plan.

Finally, management teams coordinate and provide direction to the subunits under their jurisdiction. Management teams may exist at multiple levels, such as board, senior management, or departmental levels. Management teams may also include members from multiple levels of the hierarchy. Members of management teams, by definition, have defined line responsibilities, although management teams may at times include individuals who are in non-line staff positions. Such individuals may play roles that are different from those of managers. For instance, they may serve the team in an advisory capacity with limited decisional authority.

Note that team purposes described in this section may overlap; therefore, teams often include elements of different team types. For example, a support team can be established to complete a particular project, and a treatment team might also function in a quality improvement capacity.

**Decisional Authority**

Perhaps one of the most misunderstood aspects of teams is the element we call decisional authority. Decisional authority refers to a continuum of roles that teams may play in decision making. At one end of the continuum, teams may have the authority to make decisions. The hospital board of trustees fits into this category. A self-managed work team comes close to having full decisional authority, although even these teams ultimately report to a higher authority, which may veto or otherwise alter a decision.

At the other extreme are teams with no decisional authority. These types of teams are frequently established to make recommendations, or to generate options for decision making. For example, an organization seeking to install a new information system may assign a team composed of administrative support personnel and IT professionals to provide input on their information technology needs. Alternatively, such a team may be asked to look into different vendors for a new information system and to evaluate the benefits and drawbacks of each vendor. They may or may not be asked to make a recommendation. In any event, final decision-making authority rests with senior management or a specific person or team higher in the hierarchy.

The misunderstanding about a team’s decisional authority usually results from a team having misinformation about its decisional role. Often, the decision-making authority of the team is not made clear, and teams may assume more authority than they actually have. The lesson for managers is apparent: the role of a team should be absolutely clear, particularly the role that it plays in decision making. However, even when decisional authority is made clear, team members may become disillusioned if they perceive that their recommendations or input have been ignored by the decision maker. In a team-focused
organization, it is critical that managers respect the work and time of teams and team members. Where a decision is made that contradicts a team’s recommendation, communication with team members is critical to avoid the frustration that may result from such situations. When unmanaged, disillusionment may inhibit future efforts to engage teams in similar work.

Related to team decisional authority is the decisional authority of individual team members. In some situations, the team leader has decisional authority, and team members simply provide input to the team leader. This is discussed more fully later in the chapter.

**Temporal Nature**

The third team dimension is **temporal nature**, or the permanence of a team. As noted earlier, teams can be relatively permanent and ongoing, or time-limited and focused on a particular project or task. The use of time-limited teams is becoming more common in large part because of the rapidity of change and the need to respond quickly. In the area of new product development, for example, changes in technology, shorter product life cycles, and globalization require quick and efficient development of new products (Edmondson and Nembhard, 2009). The health care industry faces similar changes brought on by technological and other environmental changes. A new strain of influenza, for example, may impact multiple segments of a hospital. It is logical to involve a multidisciplinary team approach to devising appropriate responses by the organization. Similarly, teams may be used to identify how changes in laws and regulations will affect the organization.

Whether a team is temporary or not has no bearing on its importance to the organization. What is important, however, is that **team processes** accommodate the speed that is sometimes required of temporary teams. Group process and leadership issues may need to be resolved more efficiently than in more traditional teams. Group process concerns are discussed more fully later in this chapter.

**Time and Space**

The vast quantity of research and literature on teams is predicated on teams that exist and function in a particular time and place. Advice offered on managing team meetings is based on the idea that meetings have set starting and ending times: some of this literature prescribes physical details of team management, such as optimal seating arrangements, mechanisms for ensuring full participation, and methods of dealing with people who arrive late and leave early.

With advances in communication and the ease with which **communication technology** can be used, rules of time and space often do not hold. Teams can communicate and work efficiently over any distance. As in an Internet-based chess game, teams need not meet at a specified time, but “meetings” can extend over several days if necessary, feasible, and appropriate to the team task. Team members can take hours or days to respond to a question from another team member, and one’s response can be made at any time during the day or night.

The use of the term “virtual teams” implies that much or all communication among team members takes place outside of traditional face-to-face meetings through such mechanisms as e-mail, fax, and video teleconferencing. An additional potential benefit of virtual teams is the potential to store and make accessible to team members relevant data from medical records and other sources.

Of course, not all teams are amenable to the idea of ignoring time and space constraints. A hospital treatment team generally must find times to meet in one place at a physical location. However, technology affords the opportunity for even physically constrained teams to have extended communication outside of the formal team setting. With advances in telemedicine, teams can also obtain specialized advice from experts at any distance. Thus, a radiologist in Mumbai can be a virtual member of a treatment team in rural Oklahoma. Recent studies have shown the potential for virtual teams in health care, including providing care to chronically ill patients (Wiecha and Pollard, 2007). A recent study found that a virtual health care team reduced emergency room visits by high-risk diabetes patients. Carried out at Rush University Medical Center under the auspices of the “Virtual Integrated Practice” (VIP) model, teams consisting of pharmacists, social workers, and dieticians communicated via multiple technologies, such as phone, fax, and e-mail, to help coordinate care for these patients (Rush University Medical Center, 2008). Communication technology provides many new opportunities for enhanced teamwork, including the active inclusion of patients on virtual teams.

While there is potential for growth in virtual teams, it is important to note that virtual teams require additional rules and guidance. Virtual teams enhance the ability for teams to more fluidly shift team membership according to particular
needs. This may involve the inclusion of people from outside the organization, including patients. These dynamics present additional challenges for managers. New or modified processes for team management must be designed, tested, and refined. These dynamics may also have implications for traditional reporting relationships, accountability, and reward systems in the organization. Modified measurement and control systems need to be put in place to ensure that performance is effectively monitored. Finally, since technology plays a central role in virtual teams, it is necessary for team members to be comfortable with the multiple communication technologies used by a virtual team. This is not a trivial point, particularly since virtual team members may come from different organizations (or no organization at all) and backgrounds.

Diversity

Diversity provides both opportunities and challenges for teamwork. The advantages include the opportunity to obtain multiple perspectives and expertise that are necessary for effective decision making. A major challenge resulting from diversity is managing these multiple viewpoints and worldviews and the conflicts that may result from interactions among diverse team members.

Diversity itself is multidimensional, and depending upon the team and its needs, diversity will be defined differently. In society at large, we tend to think of diversity in terms of ethnic and racial diversity, and in health care, diversity in professional backgrounds is often used when discussing teams. Among the challenges faced with multidisciplinary teams are differences in social status between professions, different worldviews, and differences in language and professional terminology and jargon. However, diversity extends into other relevant domains, including:

- **Diversity based on age and generation.** This has particular relevance in organizations as they work to accommodate the work styles of baby boomers, Gen Xers, millennials, retired persons, and others.

- **Gender diversity.** This type of diversity requires an understanding of how gender may affect one’s worldview and perceptions of problems and solutions. In health care, gender is often correlated with social status in the organization—specifically, the fact that nurses are predominantly female and physicians are now split about equally between male and female.

- **Diversity in hierarchical level.** This is particularly relevant in health care teams, where team composition may specifically require people from different levels in the organization, as well as different departments.

- **Consumer and professional diversity.** Many teams include consumers as team members. It is not uncommon for consumers to feel intimidated on health care teams because of their lack of familiarity with the norms of behavior and professional language used on professionally dominated teams. Consumers may also come from different socioeconomic backgrounds than professionals on a team, adding yet another diversity domain.

- **Demographic and cultural diversity.** Our health care organizations mirror the heterogeneous nature of society. As society in general struggles towards greater inclusiveness, organizations and teams confront the tensions, misunderstandings, and prejudices that sometimes result from a multicultural environment. Because many teams require close collaboration among its members, cultural differences may become magnified in a team setting.

Accountabilities

Just as teams have different levels of decisional authority, they also vary in the types of accountability required of them. Teams may be internally accountable, externally accountable, or both. A manager may assign a team the responsibility to complete a task; therefore, the team is externally accountable to that manager. On a project team, team members are accountable to the project team leader, but the project leader, representing the team, may be externally accountable to a manager outside of the team. Similarly, team members on a project team may also be accountable to their functional managers, a situation known as a program or matrix structure.

In well-functioning teams, team members perceive that they are accountable to each other for their individual contributions. Team communication, coordination, team outcomes, and discipline become the responsibility of team members, largely eliminating the need for external team management. In fact, in certain circumstances, an effective team leader should strive for a team that is self-managing, or has self-managing characteristics.

Membership Fluidity and Boundary Permeability

This final dimension deals with the nature of membership and team boundaries. It was noted earlier that teams may be temporary or permanent. Membership may also be relatively
stable over time, or fluid. In a medical school residents advisory committee, team membership will change quite frequently as residents leave and new ones arrive. There are liabilities to membership fluidity, including lack of cohesiveness among team members. Teams with fluid membership may have to continuously reorient team members, and new team members often take some time before they are able to make significant contributions to the work of the team. On the other hand, fluid membership may bring a continuous influx of new ideas that may benefit team performance and keep the team from becoming so inwardly focused that it loses touch with changes in the external environment. Of course, long-standing team members may resent “young Turks” who may be perceived as seeking to change the way things are done.

Related to membership fluidity is team boundary permeability. Some teams have a specific core membership that is sustained over time. The board of trustees of a hospital has a relatively stable set of team members, perhaps with a few members beginning and ending their terms each year. A team that is planning a new hospital wing will likely have a core membership that is relatively stable, but will call upon additional team members as the need arises in the course of the building project. Some members of this team may enter and exit the team several times according to the team’s needs. Consider as well the team of professionals in a hospital emergency department. Team membership changes quite frequently during the course of a 24-hour day, just as the flight crew of a passenger jet changes its composition with every flight. How do these teams function with such rapid turnover? Certainly, a hockey team that changes its membership every eight hours will likely not be as effective as a team with more stable membership. The difference is that the work in an emergency department or passenger jet is highly standardized, and the professionals who work in these settings are highly trained in the roles they play in those settings. Even in a setting as unpredictable as an emergency department, employees are trained to respond in a planned way to the unexpected. Therefore, while teams may have permeable boundaries and membership, they may still exhibit high levels of performance.

In sum, teams vary along multiple dimensions. As discussed throughout this chapter, where teams find themselves on these dimensions has important implications for team performance and team management. Teams strive for high levels of performance, and the following section addresses team performance.

**UNDERSTANDING TEAM PERFORMANCE**

We described earlier how teams represent the building blocks of organizational life and that the performance of a single employee is often determined by how well the team performs. Some may argue that too much importance is placed on how individual performance is affected by team performance. This may be true in certain types of work settings where an individual can outperform team performance. This would have its highest likelihood in a situation where there is a relative lack of interdependence between employees. For example, one could make the case (although it would contain many holes!) that an excellent elementary schoolteacher is unaffected by the overall quality of teaching in the school. We do have occasions in which excellent teachers teach in “bad” schools. It is difficult to come up with a similar situation in health care because the work of health care employees is so dependent upon the quality of others’ work.

Moving beyond individual and team levels—to the organizational level—what is the impact of team performance on the overall performance of the organization? Here, the answer is much less ambiguous than the previous discussion about the impact of teams on individual performance. Everyone in a health care organization is a member of a team, and in most cases, employees are members of multiple teams, some of which may overlap in membership. Thus, teams are the entity that makes any kind of productivity possible. It is highly likely that a health care organization with poorly functioning teams will have lower productivity (or other indicator of effectiveness) than an organization whose teams are well constituted and well managed. Given a choice, a surgical patient needing three days of postoperative care would certainly prefer a nursing unit where nurses communicate with each other accurately and often, where physicians and nurses respect each other’s views, and where all team members feel a sense of cohesion and share a stake in the quality of care provided in the unit. In a word, an informed patient would prefer a nursing unit that has the attributes of a strong team.

Some years ago, health care entered the era of accountability. Health care organizations have always had “reputations” for high or low quality, but the idea of actually measuring performance according to agreed-upon measures is relatively new. Private organizations and the U.S. government publicize quality ratings and rankings for healthcare organizations
Consider some of the most important measures used by the Department of Health and Human Services to assess hospital quality (USDHHS, 2010):

- Percentage of pneumonia patients assessed and given pneumococcal vaccination
- Percentage of surgery patients given an antibiotic at the right time (within one hour before surgery) to help prevent infection
- Percentage of patients at each hospital who reported “yes,” they were given information about what to do during their recovery at home
- Percentage of children and their caregivers receiving a home management plan for care document while hospitalized for asthma

Each of these measures is based on professionally developed guidelines. Implementation of these procedures requires that the appropriate people in the hospital have an understanding of the guidelines and the evidence that informs them. However, knowing the guidelines and the supporting evidence is very different from taking the correct action based on those guidelines. For these procedures and others, it is not difficult to uncover the role that teams play in their implementation.

With hospitals eager to earn good ratings on such quality measures, it is somewhat surprising that they do not pay more attention to those “building blocks” of quality—teams. Much attention is given to assessing the quality of clinicians through review of credentials and past work experience. This provides necessary information about hospital staff members’ technical competence, but it is inadequate to ensure that appropriate evidence-based procedures are implemented. Should hospitals have the same type of “credentialing” of teams? Given the importance of teams in implementing evidence-based practices and organizational performance, it seems advisable—at a minimum—for healthcare organizations to engage in periodic team audits that would address such questions as:

- What is the level of communication among team members in our organization? What are the strengths and weaknesses of communication on our teams?
- How satisfied are team members with how members communicate and how teams are managed? To what extent do team members feel as if they have input into decision making?
- What mechanisms do teams have in place to promote team learning and improvement in team processes and outcomes?
- To what extent do team members feel that it is safe to express themselves to other team members?
- What are the dominant leadership styles in our teams, and given what is known about team leadership, are these styles appropriate to the work of the team?
- Are we training team members and team leaders, and is there evidence that this training has resulted in improved team functioning and outcomes?
- What is the level of communication and coordination among teams? What are the specific areas that require improvement in inter-team relationships? Do our teams have specific measures to assess their effectiveness in producing desired outcomes? Are team members aware of these measures, and are they reviewed periodically by team members?

Unfortunately, such a systematic ongoing review of team processes and performance is not common in health care organizations. If hospitals and other health care organizations are interested in improving their rankings, it is important to determine the effectiveness of teams—those organizational building blocks whose output in large measure determines the rankings.

Whether we are dealing with sports teams, surgical teams, or public health surveillance teams, it is common knowledge that not all teams are equal. Some are better than others. We have all been members of teams, therefore having the opportunity to observe them in action. From these observations, it is apparent that teams vary in their effectiveness and efficiency. Why is there such variation in the performance of teams? Some variation may be due to differences in the skills of individual members, an explanation that may be salient in teams with little interdependence among its members. However, there are many situations where individual team members may be highly talented, but the team produces poor decisions that may lead to suboptimal outcomes. Later in this chapter, for example, we discuss the concept of groupthink, in which disastrously poor advice may be generated and acted upon by a team of highly talented and skilled individuals.
In the following section, we present a model of team effectiveness. Using this model, we incorporate existing evidence on the major factors that make certain teams more effective than others.

**A MODEL OF TEAM EFFECTIVENESS**

What makes some teams more effective than others? We know that teams are not naturally effective by simply bringing people together who are highly skilled at their assigned tasks. Basic team member competence is important and necessary, but insufficient to predict effective team performance. There is obviously not a single action that team leaders can take to ensure that their team will function at peak levels of performance. Nevertheless, there are actions and decisions that leaders can take to improve the probability that a team will perform at a high level. Furthermore, there are processes that leaders can put in place to maximize the probability that a team’s performance will improve over time. We adopt in this section a model of team effectiveness that includes a range of these actions, decisions, and processes. Some of these are interdependent, where implementation of one strategy is dependent upon another necessary strategy.

Notwithstanding the usefulness of this model, we also need to accept—as all managers must—that certain factors are outside of the control of the organization or manager. For example, we know that team cohesiveness is generally a positive attribute for teams, but a manager cannot always control events that may reduce team cohesion, such as turnover among team members. It is absolutely vital, however, that managers and team leaders understand and anticipate how uncontrollable factors may affect team performance. If such uncontrollable factors can be planned for, then negative impacts may be minimized. Of course, there are situations where uncontrollable factors may have a positive impact on team processes and outcomes. For instance, employee turnover tends to decrease during a recession, which in turn may lead to lower turnover among team members and sustained levels of team cohesion. An individual manager is unlikely to have much control over global macroeconomic events! However, a manager can take advantage of such “silver linings” by using the opportunity to strengthen teams and improve working conditions.

Figure 5.1 provides an overview of the multiple factors associated with team effectiveness. In the interests of simplicity, the multiple interrelationships among these factors are not included in the model, although they are addressed in the text. Moving from left to right, the model sets out three sets of factors, referred to as Team Characteristics, Nature of the Work, and the Environmental Context within which the team is situated. For each item listed, note that most are at least partially controllable by the manager, the noted exceptions being Organizational Culture and External Environment.

Moving to the right is a set of Team Process factors, many of which may be modified or controlled by the manager. Finally, Team Effectiveness factors are indicated. These include both performance outputs, such as patient outcomes, as well as team process measures, such as team member satisfaction and the capacity for team effectiveness to be sustained over time. As noted above, not illustrated in the model are potential interrelationships among these outcomes, such as the potential impact of team member satisfaction on patient outcomes.

**Team Characteristics**

*Team Size, Composition, and Diversity*

Team size has been a subject of research for many years. In general, team size has an inverted U-shaped relationship to effectiveness so that too few or too many members may reduce performance (Cohen and Bailey, 1997). As teams grow in size, communication and coordination problems tend to increase, and a climate of cohesiveness may decrease (Colquitt, Noe, and Jackson, 2002; Liberman et al., 2001). However, a team must be sufficiently large to accomplish its work. A useful rule of thumb is that teams should be staffed to the smallest number to accomplish the work (Hackman, 1987).

The U-shaped relationship between size and effectiveness is not precise. In treatment teams, performance has been found to be negatively affected by size (Alexander, Jinnett, D’Aunno, and Ullman, 1996; Vinokur-Kaplan, 1995b); in quality improvement teams, the effect was curvilinear (Shortell, 2004). Most likely, this is due to smaller teams being less cumbersome and having fewer social distractions. Smaller teams also have lower incidences of social loafing, a phenomenon in which a team member benefits from the work of the team without
making a commensurate contribution to the work of the team (Liden et al., 2004). A member’s lack of work is more visible on a small team, while individuals in larger teams may be able to maintain anonymity and gain from the work of the group without making a suitable contribution.

However, team size is often out of the control of the manager, particularly when democratic representational norms pervade an organization. In these situations, constituencies may demand to be represented, and the leader may need to design strategies to make the group more manageable (e.g., forming subcommittees). Otherwise, teams may be overstaffed. Overstaffed teams may perform work in a perfunctory, lackadaisical manner. Overstaffed teams may also lead to competition and jealousy among team members, with individuals guarding their particular domain. Alternatively, members of large teams may distance themselves from the team’s efforts and lack commitment to the team. On the other hand, breaking a team into subgroups or subcommittees has its own set of problems. When large teams are divided into smaller ones, subgroups may become cliquish and, while cohesive within themselves, may become isolated from the rest of the team.

As noted above, the impact of team size on performance is dependent upon a number of factors. Although the empirical evidence on the relationship between team size and performance is less than definitive, it is useful for managers to keep in mind the potential problems and benefits that may emerge as a result of team size.

**Figure 5.1** A Model of Team Effectiveness.

Team composition and diversity are important determinants of team performance as well. For certain types of teams, it is easier to control the membership of the group than in others. The CEO of a hospital can select from a wide variety of employees to sit on a strategic planning task force, while the director of nursing may be highly constrained in the nurses chosen for a self-managed nursing team in a pediatric oncology unit. In the latter situation, the director of nursing is limited by the pool of nurses in the unit or trained in such a specialty area. However, an awareness of likely problems related to membership helps, at least, to identify potential problems and to develop strategies to manage them. In our examination of team composition, we consider the following diagnostic questions (Hackman, 1990b):

- Is the team appropriately staffed? Is the diversity of members appropriate?
- Do members have the expertise required to perform team tasks well?
- Are the members so similar that there is little for them to learn from one another? Or, are they so heterogeneous that they risk having difficulty communicating and coordinating with one another?
- Is the team composed of members who have worked together before, and if not, how will team members learn about each other and their work styles?

Team composition may vary along a number of dimensions, such as age, occupation, gender, tenure, abilities, personality, and experience. Diversity, or the distribution of personal attributes among team members, is likely to affect the way individuals perceive each other and how well they work together (Jackson, Joshi, and Erhardt, 2003). These, in turn, may affect team performance. Most research on group composition concludes that diversity in a team is particularly desirable when the work is complex and has a limited time span (Campion, Medsker, and Higgs, 1993). Thus, diversity in team members’ abilities and experiences is particularly important (Athanasaw, 2003; Mitchell, Parker, Giles, and White, 2010). However, one study found that a balance between different levels of managerial experience was needed in entrepreneurial teams in the medical and surgical instruments industry (Kor, 2003). That is, the more effective teams were composed of members who had a balance between industry and team experience; too much of either created conflict and decreased the ability of the team to seize new growth opportunities.

Diversity has become a very important concern in health care organizations. Diversity can help to promote quality and competitive advantage by including staff who can best understand diverse cultures. Diversity can also generate a broader perspective on a problem, which may lead to superior problem analysis and suitable solutions. From a legal perspective, diversity is a concern in relation to equal employment opportunity law. Thus, it has become so important that the Joint Commission has instituted requirements for staff diversity and cultural competence (Joint Commission, 2005). Although diversity brings many advantages, it also comes with problems, such as the potential for increased conflict and a loss of cohesiveness. Researchers, finding a negative relationship between diversity and performance in new product development teams, suggest that group heterogeneity might reduce social integration and cohesion (Ancona and Caldwell, 1992b). As a result, conflict begins in the initial stages of group formation and affects performance throughout the team’s existence. In multidisciplinary health care teams, this is especially prevalent due to the differences between disciplines in basic philosophy and values, treatment modality, and terminology.

**Tenure diversity**, or the length of time members have been on the team, is also an important consideration in teams. For instance, new members coming into an already functioning team must be socialized to **team norms** (standards shared by team members that regulate team members’ behavior) and procedures, which takes valuable time away from the work of the team. Although continuity of staffing is important, boundaries of some groups are, by necessity, more permeable than others. For example, hospital teams often include different physicians and nurses corresponding to the needs of the patients at certain points in their treatment and recovery. It should be noted that having a clear mission and set of task priorities will decrease many problems associated with tenure diversity, while the use of core and peripheral members and full-time and alternate members will increase team continuity and stabilize the process (Ancona and Caldwell, 1998; Topping, Norton, and Scafi di, 2003). The diversity “liability” can also be alleviated if members have previous experience working in teams or have been given training in team-building techniques (Athanasaw, 2003; Topping, Norton, and Scafi di, 2003). Katzenbach and Smith (1993) note that successful teams do not just happen: they become effective when members have certain skills that permit them to function positively in a group.
Status Differences

Status is a measure of worth conferred on an individual by a group. Status differences are seen throughout organizations and occur in all teams. It may have the effect of motivating people and providing them with a means of identification; it may be a force for stability in the organization (Scott, 1967). Status differences can also be a negative force and a source of conflict and tension. These differences exist in all teams and can have a profound effect on team functioning and individual behavior on teams. Status differences cannot be eliminated but if well managed, can mitigate negative impacts. In this section, we discuss some of the ways that status differences affect teams and suggest strategies for managing status differences.

Status differences in health care are common and well entrenched (Lemieux-Charles and McGuire, 2006; Nembhard and Edmondson, 2006; Topping, Norton, and Scafi di, 2003). Multidisciplinary teams benefit from operating as a company of equals, yet the reality may make this very difficult. For example, in a study of end-stage renal disease teams in which the equal participation ideology was accepted by most team participants, it was clear that the physicians, who had higher professional status than other groups, had greater involvement than others in decision making (Deber and Leatt, 1986). The mismatch between expectations and reality made many team members, particularly staff nurses, feel a sense of role deprivation. That is, they were inhibited in their ability to fulfill completely their role as health professionals. This in turn led to a decrease in morale and job satisfaction. Status issues may be exacerbated in teams characterized by gender diversity, particularly when men comprise the higher status group. High-status members tend to initiate communication more often, are provided more opportunities to participate, and have more influence over the decision-making process. Thus, a lower-status team member may feel intimidated or ignored by higher-status team members. The group, as a result, may not benefit from this person’s expertise.

Status differences can profoundly affect team effectiveness. They may impede someone with less authority or status from challenging someone with more authority. Similarly, status differences may inhibit someone of higher status from hearing input from those with lower status. The term authority gradient has been used to describe differences in status and authority. Authority gradients have been identified in the airline industry as one of the causes of aviation accidents. That is, coordination and communication within the cockpit may be inhibited by differences in authority and status. In health care, authority gradients have been discussed among physicians, between residents and attending physicians, and between physicians and nurses, pharmacists, and social workers. Cosby (2009) notes as well the authority gradients between physicians in different specialties.

Status differences may affect patient outcomes. From the well-regarded IOM report, Keeping Patients Safe: Transforming the Work Environment of Nurses, “counterproductive hierarchical communication patterns that derive from status differences” are partly responsible for many medical errors (Institute of Medicine, 2003). Further, a review of medical malpractice cases from across the country found that physicians (higher-status team members) often ignored important information communicated by nurses, who had lower status on the team. Nurses in turn withheld relevant information for diagnosis and treatment from physicians (Schmitt, 1990). In a status-consciousness environment such as health care, opportunities for learning and improvement can be missed because of unwillingness to engage in communication necessary for improvement.

Some teams have developed positive norms of equality, which can certainly help to minimize the negative impact of status differences. However, norms of equality may run counter to the formal or informal status of individual group members in the larger organization. For example, within a hospital, a physician may possess and exercise his or her power. Within a CQI team, that same physician may be expected to serve as an equal in analyzing problems and recommending solutions. Is it possible for such an individual to adjust his or her attitudes and behaviors according to the norms of the particular social milieu? As discussed later in the section on Environmental Context, this is an example of the larger environment (the hospital) potentially affecting the behavior of individuals on a particular team. This discrepancy between the status one has in the external environment and within the team may pose team management challenges.

CQI teams often use training early in the team development process to cope with problems brought about by status differences. In well-managed multidisciplinary teams, lower-status individuals should feel elevated by being part of such
high-profile, effective teams. If status inequality exists, it is advisable for leaders to build a trusting environment in which members can disagree with the leader and others on the team without repercussions. In other words, the team leader should strive to achieve a climate of psychological safety for its members. In one study, NICU medical directors who were more attentive to other professions’ ideas and concerns mitigated perceptions of status differences, increased unit psychological safety, and had success implementing quality improvement projects in the units (Nembhard and Edmondson, 2006).

**Psychological Safety**

*Psychological safety* describes individuals’ perceptions about the consequences of interpersonal risks in their work environment—largely taken-for-granted beliefs about how others will respond when one puts oneself on the line, such as by asking a question, seeking feedback, reporting a mistake, or proposing a new idea in the team context. In psychologically safe teams, people believe that if they make a mistake, other team members will not penalize or think less of them for it. This belief fosters the confidence to experiment, discuss mistakes and problems, and ask others for help. Psychological safety is created by mutual respect and trust among team members, and leader behavior is a powerful influence on the level of psychological safety in teams (Edmondson, 1999, 2003).

Management research on psychological safety started with studies of organizational change. When Schein and Bennis (1965) discussed the need to create psychological safety for individuals if they are to feel secure and capable of changing. Psychological safety helps people overcome the defensiveness, or “learning anxiety,” that occurs when people are presented with data that disconfirm their expectations or hopes, which can thwart productive learning behavior (Schein, 1985). However, the need for a team climate conducive to learning does not imply a cozy environment in which people are close friends, nor does it suggest an absence of pressure or problems. Team psychological safety is distinct from group cohesiveness; team cohesiveness can reduce willingness to disagree and challenge others’ views, creating groupthink (Janis, 1982). This represents a lack of interpersonal risk taking. Psychological safety describes instead a climate in which the focus is productive discussion that enables early prevention of problems and the accomplishment of shared goals, because people feel less of a need to focus on self-protection.

Although few people are without concern about others’ impressions, our immediate social context can mitigate—or exacerbate—the reluctance to relax our guard. Research in hospitals and other organizations has found differences across teams in people’s willingness to engage in behavior for which the outcomes are uncertain and potentially harmful to their image. When psychological safety is high, teams are much more likely to engage in learning, which in turn promotes team performance (Edmondson, 1999). Just as compelling goals are necessary to motivate learning, psychological safety enhances the power of such goals by facilitating less self-conscious interpersonal interactions. Without a goal, there is no clear direction to drive toward and no motivation to exert the effort; without psychological safety, the risks of engaging wholeheartedly in learning behaviors and other key team processes in front of other people are simply too great. In one recent study, unit psychological safety was associated with implementation success of quality improvement projects; when unit members were able to raise questions and concerns, they were better able to understand the rationale behind proposed changes and more able and willing to implement them quickly (Tucker, Nembhard, and Edmondson, 2007).

**Team Norms**

A team norm is defined as a standard that is shared by team members and regulates member behavior. *Behavior norms* are rules that standardize how people act at work on a day-to-day basis, while *performance norms* are rules that standardize employee output. Behavioral norms in teams are far reaching and may vary substantially from one group to another in the same organization. Norms may govern how much each individual participates in the team’s work, how humor is used, the use of formal group procedures (e.g., Robert’s Rules of Order), and responses to absence and lateness. In their study of operating room nurses, Denison and Sutton (1990) describe their surprise at the behavioral norms present in the operating room:

> At first we were surprised by the norms of emotional expression in the operating rooms. The first time we entered the room where a coronary bypass operation was being done, for example, we were surprised by the loud rock music blaring from the speakers, the smiles on the faces of the surgical team, and the constant joking. Denison observed one surgeon who joked and told a series of funny stories as he performed the complicated task of cutting the veins out of a patient’s leg—veins
that would be used to bypass clogged coronary arteries. Similarly, one reason that Sutton almost passed out during a tonsillectomy was that he became very upset when the surgeon laughed, joked, and talked about “what was on the tube last night” while blood from an unconscious child splattered about.

Norms are powerful influences in organizations and teams, and the existence of norms is necessary for effective group functioning. In Hackman’s (1976) classic Work Redesign, he suggests that norms have the following characteristics:

1. Norms summarize and simplify team influence processes. They denote the processes by which teams regulate member behavior.
2. Norms apply only to behavior, not to private thoughts and feelings. Private acceptance of norms is not necessary; only public compliance is required.
3. Norms are generally developed only for behaviors that are viewed as important by most team members.
4. Norms usually develop gradually, but members can quicken the process. Norms usually are developed by team members when the occasion arises, such as when a situation occurs that requires new ground rules for members in order to protect team integrity.
5. All norms do not apply to all team members. Some norms apply only to newer members, while others may be applied to individuals based on seniority, sex, race, economic status, or profession.

Because of the significance of norms in effective group functioning, it is important to clarify norms publicly so members will know what is expected. This is especially the case for multidisciplinary teams in hospitals and other health care settings (Deeter-Schmelz and Ramsey, 2003). If acceptable norms are established as part of the group process in a multidisciplinary team, there is less chance of the team being dominated by one discipline (Vinokur-Kaplan, 1995a).

**Team Cohesiveness**

There are a variety of definitions for team cohesiveness, many of which focus on the degree to which members of a group are attracted to other members and, thereby, are motivated to stay in the group. Another, more narrow definition that better fits the purpose of this chapter is used by Goodman, Ravlin, and Schminke (1987): “cohesiveness is the extent that members are committed to the group task.” In this definition, the focus is on the decision to produce, and it acknowledges that members can be committed to a common task but not necessarily be attracted to each other. This is a pragmatic view of cohesiveness that is particularly important for focusing on the management of teams in which members, such as nurses, physicians, psychologists, and social workers, are already highly committed to professional standards.

Cohesion is an important component in understanding group process and effectiveness. Highly cohesive teams may exhibit higher levels of performance, greater member satisfaction, and lower levels of turnover (Gully, Devine, and Whitney, 1995; Hoegl and Gemuenden, 2001; Yang and Tang, 2004). The relationship between cohesion and effectiveness is particularly strong when the work of the team is complex, requiring high levels of coordination, communication, and mutual performance. Specifically, research focusing on treatment teams in psychiatric hospitals, engaged in highly interdependent work, found that cohesive teams had higher performance levels than less cohesive ones (Vinokur-Kaplan, 1995a). Similar findings resulted from a study examining the effectiveness of geriatric rehabilitation teams (Wells et al., 2003).

Cohesion among team members is a key determinant of team effectiveness. Cohesiveness can also promote better enforcement of group norms and general control over group members; however, taken to extremes, this can lead to situations of undue or dysfunctional conformity. For instance, there are circumstances under which high levels of cohesiveness can lead to lower levels of productivity. That is, if a group’s norms favor low productivity, then having a highly cohesive group will likely lead to high levels of conformity to this norm and, hence, lower productivity. Similarly, a highly cohesive team may work against a manager’s efforts to involve new team members, or to encourage interaction with other teams. Cohesiveness, therefore, should be viewed in context. In most situations, it is a positive force, while in others, it can lead to conformity and counterproductive norms and practices.

What are the sources of cohesiveness? A central tenet of social psychological theory is that individuals are attracted to others who are similar to them; therefore, homogeneous groups should be more cohesive than heterogeneous ones. All-female groups, for instance, tend to be more cohesive than all-male and mixed sex groups (Bettenhausen, 1991).
The lack of conflict, team training, a positive predisposition for teamwork, and the presence of trust among members also lead to increased cohesiveness (Deeter-Schmelz and Ramsey, 2003). To complicate matters, some research suggests that conflict may be beneficial to group performance, particularly when a group is dealing with complex problem-solving tasks (Cosier, 1981; Janis, 1972; Schwenk, 1983). In this sense, multidisciplinary teams and cultural diverse teams, while potentially exhibiting higher levels of conflict and less cohesiveness, may also be more creative and innovative in their approach to problem solving (Mitchell et al., 2010).

The cohesiveness of a team is also influenced by the goal orientation or reward structure of the team. Let us consider two conditions. First is the situation of goal interdependence in which members are evaluated and rewarded as a team (i.e., equal reward structure). Here, progress to each member’s professional/personal goals is identical to progress to team goals. The second condition is one in which group members are judged and rewarded as individuals (i.e., unequal reward structure). In essence, one member may reach his or her goal at the expense of another team member. In general, the findings support the first or cooperative condition (Parker, McAdams, and Zielinski, 2000; Yang and Tang, 2004). Team members in the second situation are more likely to be highly competitive, leading to lower cohesiveness due to:

- Less inter-member influence and acceptance of other’s ideas
- Greater difficulty in communication and understanding
- Less coordination effort, less division of labor, and less productivity

Following from this, cohesive groups tend to have levels of interaction that are greater and more positive, which is strengthened by conditions of high interdependence. That is, groups that have equivalent reward structures not only perform more efficiently, but also develop cooperative strategies such as teamwork and pooling of information that facilitate achievement of jointly shared goals.

**Nature of the Work**

Organizational research has for many years adopted the principle of contingency; specifically, that organizational structures and processes must be aligned with a number of factors. That is, there is no one best way to organize; optimal organizational mechanisms depend upon environmental factors, the technology used, and the nature of the work done by the organization. Among the underlying themes in research on teams is that team tasks can be classified according to their critical demands; that is, critical features of a task dictate particular team behaviors essential to successful performance. These specific behaviors include not only individual effort, but also cooperative and interdependent endeavors. This means that effective performance is a function of matching team process to task demands. In this section, we identify key aspects of the tasks confronting teams and the manner in which teams adapt to different task characteristics. In addition, we consider two aspects of the work of a team: goals, and the level and type of task interdependence.

**Team Goals**

Team goals and their accompanying tasks can be categorized according to goal clarity, complexity, and diversity. Each of these dimensions has implications for the manner in which a team is organized and managed. For example, some teams work toward goals that are repeated over time. In these situations, communication and coordination mechanisms among team members can be routinized. Although they face variations and some uncertainty, obstetrical teams face a defined set of goals, namely the safe delivery of newborns and the health and well-being of mother and child. The goals and accompanying tasks for such teams and for individual team members are well structured and understood by team members. Where goals and tasks are relatively predictable, and where team members understand exactly what is to be done, the work of a team can become highly routine.

Contrast this situation with teams facing ambiguous, ill-structured goals. A disaster preparedness team is perhaps the epitome of this type of uncertainty. In such a situation, communication is of paramount importance. Team members must be prepared to adapt to new circumstances, and adjust their work according to the situation. Ongoing coordination and mutual adjustment among team members are essential, since routinization may be possible only up to a point.

Goal and task clarity were significant variables in determining the performance of hospital treatment teams, allowing them to meet the hospital’s standards of quality, quantity, and timeliness (Shaw, 1990; Vinokur-Kaplan, 1995a). Task complexity is related to team interaction; the more complex the task, the greater the need for interaction, so that it is important that managers plan for enhanced communication.
among the team members under conditions of complexity. Others have found that an increase in task diversity, as defined by the number of different conditions treated within ICUs, challenges caregivers since their expertise and knowledge can be applied across a wider range of conditions, and leads to better outcomes (Shortell et al., 1994).

**Task Interdependence**

Another form of task diversity focuses on interdependence, which is generally the reason why teams form in the first place. **Task interdependence** refers to the interconnections between tasks, or more specifically, the degree to which team members must rely on one another to perform work effectively. A useful way of classifying task interdependence is the hierarchy of task interdependence based on exchange of information or resources (Thompson, 1967; Van de Ven, Delbecq, and Koenig, 1976):

- **Pooled interdependence** is a situation in which each member makes a contribution to the group output without the need of interaction among members. Since each group member completes the whole task, team performance is the sum of the individual efforts. Standardized rules and procedures are needed to enhance coordination of team outputs.

- **Sequential interdependence** is a situation in which one group member must act before another one can. Group members have different roles and perform different tasks in some prescribed order, with the work flowing in only one direction. There is always an element of potential contingency since readjustment is necessary if any member fails to meet expectations. Coordination using schedules and plans is needed to keep the team on track.

- **Reciprocal interdependence** is a situation in which the outputs of each member become inputs for the others, such that each member poses a contingency for the other. Group members often are specialists with different areas of expertise and have structured roles; therefore, they perform different parts of the task in a flexible, “back-and-forth” order. Leaders must provide for open communication between members and scheduled meetings as necessary.

- **Team interdependence** is a situation in which team members must actively coordinate to diagnose and solve problems, or otherwise carry out work or work-related activities. The workflow is simultaneous and multidirectional.

Coordination requires mutual interactions with group autonomy to decide the sequencing of inputs and outputs among members. Leaders should plan frequent meetings, while also encouraging unscheduled ones.

The higher the level of interdependence, the greater the uncertainty faced by a team and its members. Therefore, as the degree of interdependence among team members increases, so does the need for information exchange and processing, coordination, communication, and cooperation. Implicit in this is the need for matching the information exchange and processing needs requirements with appropriate interaction and coordination patterns that facilitate information exchange.

If team members perceive low interdependence when high interdependence actually exists, then too little effort will go toward coordination. On the contrary, when interdependence is perceived as higher than it really is, too much effort may be expended in coordination behavior at the expense of performance. For this reason, interdependence and the level and type of coordination must be appropriately matched. Some researchers go so far as to suggest that successful teams are the ones that match interdependence in terms of task, goal, and feedback. That is, a successful team is one in which reciprocal work is matched with group goals and group feedback. Group goals and feedback mean that rewards would be based on the group goal and feedback given on the group’s performance as a whole. Conversely, pooled interdependence should be matched with a situation of individual goals and feedback.

Regardless of the task characteristic, the important point for managers is the need to match team tasks with process and structure. One study demonstrating this matching described the reengineering effort in a large urban hospital system that used teams for overcoming care delivery problems, particularly fragmentation and discontinuities in delivery (Schweikhart and Smith-Daniels, 1996). Focused teams, or relatively autonomous operating units, were formed by merging multidisciplinary clinicians into patient care units, so that pharmacists, respiratory therapists, nurses, and other caregivers were integrated through shared governance and cross-training. The teams were given high levels of autonomy and accountability, while sharing responsibility for both care production work—execution of the patient’s care plan—and care management work—planning and coordinating the care. In this case, high levels of task complexity and interdependence were matched with a team structure that allowed increased levels of communication and interaction.
In virtual teams, team members may be separated not only by geography and time, but also by culture and language. In this situation, managers are faced with the dual challenges of coordinating work among individuals from different disciplines and from different cultures (Barczak and McDonough, 2003). In health care, this type of team is most common in product development (for example, pharmaceuticals and medical equipment) and in clinical research.

Environmental Context

Teams do not exist and function in a vacuum, but operate within a broader environmental context. They are affected by pressures and events from outside of the immediate team. In this section, we examine several critical external factors that may affect team performance: intergroup relationships and conflict; organizational culture; and the larger external environment.

Intergroup Relationships and Conflict

An important part of a team’s external environment is the presence of other teams. In many situations, effective team performance is dependent upon a team’s ability to form intergroup relationships with other teams in a positive and productive manner. In complex organizations, one of the most challenging tasks of many teams is to interact with other teams whose work is related to theirs (Edmonson, 2002). For example, consider the myriad intergroup interactions among teams that must occur in the merging of two hospitals (see Sidorov, 2003; Dooley and Zimmerman, 2003; Yang and Tang, 2004). Teams assembled to deal with staffing issues, technology, finances, architectural concerns, and countless other factors must work with other teams in both their own group and the merging organization. One could only imagine the confusion if each team chose to work without the advice and input of other teams.

What happens when teams must coordinate their efforts? What are the factors responsible for effective and ineffective intergroup relationships in this context? Intergroup relationships are often lateral, or peer, relationships, rather than hierarchical ones. As health care organizations have moved away from rigid hierarchical structures to manage work, and as they have become more specialized, the need for new coordination mechanisms has increased such as cross-team training, virtual team updates, and joint meetings for planning and coordination.

In the process of working out intergroup challenges and coordination issues, intergroup conflict is perhaps inevitable. Given the uncertainty and heterogeneity of inputs in health care, it is virtually impossible to design all work processes in advance in such ways as to ensure that the work of all groups mesh perfectly with the work of other groups. When conflicts or disagreements occur among groups, it is important that team members possess a repertoire of conflict resolution strategies. In some cases, the interfaces among teams require only fine tuning; in the worst situations, work processes may need to be overhauled to achieve functional intergroup relationships.

Some intergroup conflict results from interpersonal differences or animosities. However, most intergroup conflict emerges because of factors related to the interdependent multiple teams. This is especially true for health care organizations, which are known for high levels of interaction and, therefore, present more opportunities for the emergence of conflict. Conflict between groups cannot usually be addressed at an individual level; one member of a group can rarely resolve an intergroup conflict in a unilateral manner. If intergroup conflict is viewed as resulting from problems in the interface between groups, then the analysis of the causes and sources of conflict should examine the nature of relationships.

First, intergroup conflict is more likely to occur when there is ambiguity about the team’s respective task responsibilities and roles. This situation largely explains conflicts that occur between professional groups with overlapping practice domains, such as between psychologists and psychiatrists (Brown and Keyes, 2000; Weist et al., 2001). Task and role ambiguity may also be common in organizations undergoing rapid growth or change, where different groups may have divergent understandings of the nature and implications of change. Consider the conflict that may occur when an organization is in the midst of a merger (Dooley and Zimmerman, 2003). This type of conflict points to the need to articulate team roles clearly and distinguish precisely the responsibilities of similar groups.

Conflict may also arise from intergroup differences in work orientation. Every team develops its own set of norms regarding the manner in which work is accomplished. In many organizations, teams have different perspectives on time. This difference in time orientation was identified and managed when strategic planning was attempted with a group of family physicians (Fried and Nelson, 1987):

By its nature, the activity of planning is at odds with the role orientation of most physicians. Planning is a long-term process in which the results of strategic decisions appear over time. The outcomes of planning
are often intangible in the short term. By contrast, physicians are trained to be action oriented.

It was discovered early in the planning process that physician attendance at meetings decreased when the pace of work lagged. Therefore, whenever possible, the pace of work was increased to a level more acceptable to physicians. A work plan with specific deadlines was followed.

Related to differences in work orientation is the problem of goal incompatibility among teams. Teams whose goals are in conflict (or perceived to be in conflict) must sometimes work together. A common conflict in health care is between teams whose orientation is primarily cost containment and teams whose orientation is focused more on quality concerns. At other times, differences in group culture may cause conflict between teams. Each group develops its own unique norms, communication network, and values, which collectively is referred to as a team culture. When these vary between teams, conflict often occurs. Lastly, intergroup conflict may occur when there is competition for resources. Teams may have much in common and be oriented toward the same goals, yet experience conflict because they are competing for the same limited financial, human, or physical resources. In hospitals, the change to product or program management would tend to increase the likelihood of intergroup conflict as product-line teams develop internal competitive thrusts.

Perhaps of greatest importance for the organization as a whole, as conflict emerges between groups, cooperative relationships may be replaced by a win-or-lose mentality. In this case, victory becomes more important than solving the problem that may have caused the conflict in the first place. Because of this, it is important to develop strategies that can be used in managing and reducing intergroup conflict.

**Organizational Culture**

Among the most important environmental factors affecting team performance is the organizational culture of the larger organization. For teams to function to their maximum potential, it is extremely important that a suitable culture exists—one that values and emphasizes teamwork and participation (Zarrage and Bonache, 2003). Among the most common complaints about teams in organizations is that they do not receive adequate support from the larger organization. While many organizations claim a commitment to a team-based organization, they often lack effective culture and strategies for accomplishing this transition.

How does senior management of an organization adopt a team-based culture? First, it is important for senior management to internalize the concept of a team culture, and to understand fully how a team culture is consistent with and supportive of its overall strategy. Furthermore, this needs to be communicated throughout the organization. Senior management also needs (1) to believe that employees want to be responsible for their work; (2) to be able to demonstrate the team philosophy; (3) to articulate a coherent vision of the team environment; and (4) to have the creativity and authority to overcome obstacles as they surface (Moorhead and Griffin, 1998; Orsburn, Moran, Musselwhite, and Zenger, 1990).

As with other aspects of organizational life, teams require strong support from senior management to be effective (Liberman et al., 2001). By support, we refer to philosophical backing and resource support. Resource support includes money, human resources, training, and time. Once senior management has made a commitment to teams, it may be necessary to develop a detailed implementation plan. This plan might include a clarification of the organization mission to focus on such things as continuous improvement, employee involvement, and customer satisfaction; selecting sites for teams; preparing a design team to assist with team staffing and operation; planning the transfer of authority from management to teams; and drafting a preliminary plan for implementation. To be successful, teams need an internal champion who can provide motivation, encouragement, and work to acquire the resources and support required (Cohen and Bailey, 1997; Shortell et al., 2004).

Training constitutes a key part of implementing and supporting teams, and to be effective, the organizational culture must support its use (Liberman, 2000). No one would ever consider the possibility of a soccer team being successful without substantial training or practice. Based on the experience of countless non-sports teams, the need for training—in fact, continuous training—is very apparent. There is a vast literature on selecting and training individuals to work in teams, and the knowledge, skills, and abilities necessary for effective teamwork. Such training may include cognitive content, including the rationale or raison d’être of having a team-based organization. Affective content should also be addressed, including the roles and responsibilities of team members and team norms as well as logistical issues dealing with meeting management and the reward system (Moorhead and Griffin, 1998). Other examples include team interaction training that can lead to shared mental
models (Marks, Zaccaro, and Mathieu, 2000); problem-solving and decision-making training, which can enhance interdisciplinary team interactions (Doran et al., 2002); and newcomer training, which can speed the socialization process (Chen and Klimoski, 2003). Overall, for team training to be comprehensive, it optimally should include requisite technical, administrative, and interpersonal skills.

The reward system of the organization should optimally reflect the organizational culture. Thus, a particular dilemma facing managers in team-oriented organizations is the question of type of reward system. To what extent should the organization bestow team, as opposed to (or in addition to) individual, rewards? The organization also needs to address one of the unanswered questions in organizational research: do team-based rewards improve team and/or individual performance? Despite the equivocal nature of the literature in this area, there seems to be a natural tendency for team-oriented organizations to at least consider the idea of team-based rewards. In a team-based environment, a variety of mechanisms may be employed to reward team and team member performance. Team members may be rewarded for mastering a range of skills needed to meet team performance goals. Compensation or other rewards may also be given for team achievements and performance. Skill-based pay may reward employees for acquiring specific skills needed by an employee’s team. Team members may increase their compensation by acquiring value-added skill sets. Team bonus plans reward particular teams based on the performance of the team. Finally, gain-sharing plans (usually considered an organization-wide incentive system) typically reward all team members from all teams based on the performance of the organization as a whole.

It should be stressed that while there are many options for rewarding team performance, the number of organizations that actually use team-based incentives is relatively small. A survey of 2,500 corporations found that the number of companies with group incentives grew from 16 percent in 1995 to 19 percent in 1996 (Pascarella, 1997). While this growth is notable, the majority of organizations have not implemented team-based incentive systems. Part of the reason for this is the complexity of such schemes and the lack of agreement on the link between incentives and performance. While there is an intuitive appeal to performance-based compensation, there exists substantial dissent regarding the whole premise of pay-for-performance. Many managers and scholars believe that such schemes are highly destructive to individual, team, and organizational performance. In addition, there are a number of critical questions that need to be resolved to ensure that a team payment system does not yield unintended negative consequences, including (Pascarella, 1997):

- Does the team as a whole receive rewards, or do individuals on the team receive rewards for outstanding team performance?
- If rewards are not uniformly distributed among team members, how does management assess the relative contributions of different team members?
- Should team members be compensated for results, behaviors, or both?
- How should people be rewarded when they have membership on multiple teams?

These are critical questions, the answers to which depend upon the particular manner in which teams are used in the organization as well as the culture of the organization (Beersma et al., 2003). However, several hybrid compensation structures have been successful in simultaneously motivating low-performing team members to improve while encouraging high-performing members to help in this process (Katz, 2001). An example of a hybrid plan involves a team threshold; once the team as a whole reaches this level, pay increases are based on individual performance. This is especially successful when there are enough highly skilled workers on the team to teach their less-skilled or less-knowledgeable colleagues.

**External Environment**

Besides the organizational environment, teams are affected constantly by influences from the external environment as well. This makes it important to understand how external factors influence team process and effectiveness (Ancona, 1990; Arrow et al., 2000). Most research has involved organizational factors that affect teams (e.g., support from senior levels of the organization), so there is little known about the effect of external environment (Lacey and Gruenfeld, 1999). For many groups, the greater external environment may exert influence equal to or greater than the internal organizational environment (Hackman, 2003; Salas, Burke, and Cannon-Bowers, 2000). This is particularly true for multidisciplinary, interagency groups that interact with and depend on not only member organizations but also the community environment and local service network for critical resources and support.
These teams often are used in resource-deficient rural areas to extend services, making it critical to understand how these conditions affect teams and how to develop strategies to overcome the effects.

In several studies (Fried et al., 1998; Topping and Calloway, 2000), the findings indicated that resource scarcity was an important issue in the development of mental health delivery systems in rural environments. In areas with high levels of resource scarcity, only a few core providers took a central or gatekeeper role, thereby implying that organizations in that system act more autonomously than a system with more resources. This, in turn, will affect the collaborative behavior or social capital existing in the provider network, in specific, and community, as a whole. Social capital can be best defined as the web of cooperative relationships between providers in a service system that involve interpersonal trust, norms of reciprocity, and mutual aid (Veenstra, 2000). In situations of scarce resources where social capital may be low since organizations tend to interact less, there will be little impetus to use teams to solve interorganizational problems. For instance, teams including acute care hospital nurses and community providers are used to provide care to older people discharged from the hospital (Robinson and Street, 2004). In these situations, collaboration among team members would be much more difficult.

Another contextual factor influencing collaboration between team members is the collaborative history of the provider network or community. Interagency teams, whose members have a long history of service coordination, tend to report a remarkably easy process of forming and becoming a cohesive, effective team (Topping, Norton, and Scafi di, 2003). There are also rural and urban differences. Many rural areas report that, “everyone knows each other and have worked together before.” Thus, a sense of “teamness” is there from the beginning. In addition, urban communities tend to include a larger number of service organizations, so that interagency teams usually are composed of many professionals, while rural areas have to depend on nontraditional groups such as the YMCA, churches, and Boys and Girls Clubs, for members. This, of course, increases diversity, which may also increase team conflict (Jackson, 1992; Kor, 2003).

**Team Processes**

Up until this point, we have discussed basic team characteristics such as composition and norms, the type of work done, the environment within which teams operate, and interrelationships among these factors. In this section, we focus on how teams do their work—how they are led, the manner in which communication is handled, how they make decisions, and other processes and procedures. Team process thus refers to the methods of interacting and performing work by team members alone and in interaction with each other. Processes addressed in this section are leadership, communications, decision making, learning, and how the work of the team is affected by its stage of development.

**Leadership**

Leadership in teams refers to the ability of individuals to influence other members toward the achievement of the team’s goals. This definition permits us to include formal and informal leadership. By formal leadership, we refer to legitimate authority given to a team member. In some cases, an external individual in a position of authority can assign leadership, or in other instances, leaders may be designated by team members through voting or other forms of consensus. By informal leadership, we refer to individuals who assume leadership roles based on some personal characteristic. A number of factors can give rise to informal leaders, including expertise, experience, or personal charisma.

Related to but distinct from leadership is power. Some team members may acquire and exert power in a team through their relationships with individuals outside of the team. For example, in an academic medical center, a team member whose spouse is a vice president may be in a position to wield considerable power. A team member may also obtain power because they are perceived to be non-substitutable, or difficult to replace, in the organization. Some people may also achieve power because they have the ability to cope with uncertainties faced by the organization. An IT staff member may achieve an inordinate amount of power because her skills and knowledge are scarce, and because of her ability to cope with a major uncertainty—the risk that the information system will fail, causing potentially widespread disruption to the work of the organization.

Some teams have multiple leaders. For instance, there may be a formal leader as well as several informal ones. Informal leaders can be supportive of the formal leader, or can undercut the authority of the formal leader. Examples of formal leaders are head nurses, department managers, and project committee chairs. As noted before, formal leaders have legitimate authority over the team. That is, the organization has granted these individuals power along with some ability to use formal
rewards and sanctions to support that authority. However, the formal leader may not be the most influential person on the team. The extent to which team members accept the formal leader’s wishes is, in large part, determined by the reaction of the informal leader(s) to those wishes.

Note that there is a difference between ad hoc groups, such as parallel and project teams, and formal work teams. In a parallel or project team, an informal leader may be selected as the group’s formal leader. This is the rationale for appointing high-profile individuals to chair significant CQI teams or to serve as “honorary chairs” of important search committees. In work teams, however, there is no opportunity for choice. It may be that the formal leader is not the person on whom the team depends, but it is the “informal leader who embodies the values of the group, aids it in accomplishing objectives, facilitates group maintenance, and usually serves as team spokesperson” (Hunsaker and Cook, 1986).

Leadership in teams has been studied extensively and has included both formal and informal leadership. That is, the important distinction is often not between formal and informal leadership, but between effective and ineffective leadership. In one study, leadership in intensive care units (ICUs) was positively related to efficiency of operation, satisfaction, and lower turnover of nurses (Shortell et al., 1994). Successful leaders adopted a supportive formal or informal leadership style, emphasizing standards of excellence, encouraging interaction, communicating clear goals and expectations, responding to changing needs, and providing support resources when possible. In another study, surgeon leadership was critical to the successful implementation of a new technology (Edmondson, 2003). Successful leaders communicated a compelling rationale for the change, motivating others to exert the necessary effort, and also minimized the status difference between themselves and other members of the operating room team, to facilitate others’ ability to speak up with questions, observations, and concerns.

Team leaders vary in the style of leadership they adopt, and different circumstances call for different styles of leadership. In deciding upon a leadership style, therefore, group leaders need to consider in realistic terms their formal and informal authority within the group. Use of a coercive or forceful style may backfire when the individual does not have the power to back up decisions. Such a leader may find that the informal leader is able to veto, modify, or sabotage demands. Webster et al. (1998), using case management teams, found that “powerless leaders” were faced with the formation of cliques and competition from more influential members. It is best, therefore, for the formal leader not only to consider the views of informal leaders, but also to collaborate with them if possible. It is therefore wise for a formal team leader to know the identity of the informal leader(s) and positively engage him in the work of the team.

Communication Network and Interaction Patterns

A team cannot function effectively unless members can exchange information. Team leaders are usually best positioned to help manage communications within a team and between the team and external teams and other entities (Hackman, 1982). Consider the case of a nurse in a neonatal intensive care unit, who has just met with a patient’s physician and must pass on vital information to the nurse on the next shift as well as to the parents who will visit during the next shift. How does information get conveyed? Without workable communication structures, important information may be lost or inaccurately communicated. In fact, the evaluation and design of communication processes are important components of many quality improvement projects (Tucker et al., 2007).

Communication speed and accuracy in a team are influenced by the nature of the team’s communication network and by the complexity of its task. When a task is simple and communication networks are centralized (e.g., a wheel-and-spoke structure), speed and accuracy are enhanced in a team. However, when tasks are relatively complex, centralized communication networks lower both speed and accuracy because people serving as network hubs (i.e., information disseminators) may suffer from information overload. In this situation, communication networks are best decentralized (e.g., a star-shaped structure), relieving a manager of the need to filter (and possibly distort) information before it is passed on. In the example of the neonatal intensive care unit, it would be inefficient and risk error to have a nurse on the earlier shift communicate needed information to a head nurse first, who would then pass it on to the next shift’s nurse. Timeliness and accuracy are both served by direct communication between the two nurses on the front lines of care. The team should thus use a communication structure that encourages direct interaction between nurses on sequential shifts.

The team communication network can be best described in terms of process behavior and interaction strategies...
(Coopman, 2001; Stewart and Barrick, 2000). This involves the type of interaction that occurs between members (Stewart and Barrick, 2000). Most measurement of this behavior is based on the classic work of Bales (1950), who separated group process into either maintenance behaviors or task behaviors. The maintenance category includes interpersonal activities that lead to open communication, supportiveness, and reduction of interpersonal conflict. Task behaviors are those that relate directly to the team’s work on its task. Using such a classification system, it should be possible to determine how team interaction develops and to assess the effectiveness of the process (Hackman, 1987).

In a study of multidisciplinary, interagency teams coordinating services to youth with serious emotional disturbances, it was found that new teams engaged in more maintenance behavior than older, more experienced teams (Topping, Breland, and Fowler, 2004). Moreover, the focus on maintenance interactions occurred throughout team meetings indicating that teams in the forming stage do interact differently. As a result, the new teams had less task-oriented interaction; therefore, they reviewed fewer cases and engaged in less task-oriented behavior.

Although most of the focus in teams is on internal communications, teams also rely on external relationships to perform well (Gladstein, 1984). Boundary-spanning activities help teams coordinate with other teams in the organization and ensure that team activities serve the needs of the organization as a whole. New product or new technology teams, for example, use a diverse array of members, including researchers from the marketing department, physicians from the medical staff, and senior managers. All members take on boundary-spanning roles, because all members are responsible for representing and communicating with their external function while also working interdependently with other members of the team. Ancona and Caldwell (1992a) use the following classification to describe the range of boundary spanning activities observed in their research:

**Ambassador activities**: Members carrying out these activities communicate frequently with those above them in the hierarchy. This set of activities is used to protect the team from outside pressures, to persuade others to support the team, and to lobby for resources.

**Task coordinator activities**: Members carrying out these activities communicate frequently with other groups and persons at lateral levels in the organization. These activities include discussing problems with others, obtaining feedback, and coordinating and negotiating with outsiders.

**Scout activities**: Members carrying out these activities are involved in general scanning for ideas and information about the external environment. These differ from the other two in that these activities relate to general scanning instead of specific coordination issues.

Generally, effective teams engage in high levels of ambassadorial and task coordinator activities and low levels of prolonged scouting activities. They found that other, “isolationist” teams neglected external activity altogether and thus tended to do quite poorly, probably due to being out of touch with the environment in which they work. In addition, some groups such as R&D teams use boundary spanning as an effective means of communication, but have found that stakeholder (customer) ratings were highest when the project leader—not the team—was the source of information (Hirst and Mann, 2004).

In sum, the increasing reliance on teams in health care organizations and the expanding responsibilities placed on them require strong communication structures both within the team and between the team and other groups outside the boundaries.

**Decision Making**

Most teams are involved in making decisions at some point. This does not mean that all team members are involved in making all decisions, or even that the team itself makes decisions. To illustrate, a hospital president may ask for a recommendation on a decision from his or her senior management team, but retain the right to make the final decision. Similarly, a physician may obtain input from a variety of professionals but make the final determination on treatment. Managers and team leaders can decrease the chance of misunderstandings by clarifying the role of the team and the role of each member in a particular decision. Team members can deal with limitations on their influence as long as the boundaries of their influence are clear.

In contrast, decision making in a multidisciplinary research team—set up to produce high-quality research by leveraging a diversity of inputs—calls for a highly participative approach, with considerable dialogue and discussion prior to coming to a decision. Decisions in this setting may be based on consensus and compromise (Edmondson, Watkins, and Roberto, 2003).

A third scenario is a situation in which a decision is needed quickly. Under these circumstances, it may not be possible to obtain extensive participation for a particular decision. For example, decision making in an emergency triage team
may be made without full consultation because time is critical and decisions must be made quickly and often by a single individual. Clearly, we would not want to use an elaborate team decision-making process (such as one that might be used by the multidisciplinary research team described above) in an emergency department! Conversely, given the ambiguities faced in research and the need for multiple perspectives (and few urgent time constraints), we would not want one individual making unilateral decisions in that context.

Leaders may also find the need to clarify the difference between problem solving and decision making. Some groups, such as some process improvement teams, are established to solve problems or seek methods for improving a particular organizational process. However, they may not be given authority to actually implement their solutions, particularly when substantial resources are required.

The process by which information is exchanged and decisions made is of central importance. Teams naturally attempt to make correct decisions, applying all available information to the issue at hand. One common problem that prevents complete sharing of information among members of a team is that of the free rider. The term “free rider” (referred to also as “social loafing”) refers to a member of a team who obtains the benefits of group membership but does not accept a proportional share of the costs of membership (Albanese and Van Fleet, 1985). The free rider is seen as someone who promotes self-interest (the personal acquisition of benefits) over the public interest (the need to contribute to the activity that produces those benefits). It is often observed that the larger the group, the greater the free rider effect (Roberts and Hunt, 1991).

What can managers do to minimize free riding? Through effective use of power, design of organizations (including the size of the organizational units), and control of the incentive system, managers can influence team member behavior (Albanese and Van Fleet, 1985). At a routine level, this influence may be achieved by offering financial incentives or special forms of recognition to particular group members. In the longer term, it is important for managers to deal with the free rider problem by attempting to broaden the individual’s concept of self-interest by creating, communicating, and maintaining a group culture that views effort expended on team processes as contributing to a shared goal that is meaningful to each team member.

Information may be available in a team, but effective use of that information for decision making does not always occur. First, unique information (known by only one member) may not surface in group discussions (Stasser, 1999). Experimental studies have demonstrated that groups tend to dwell on common information (that held by all members), such that privately held information fails to surface; further, when it does surface, its impact is often muted (Larson et al., 1996).

Second, teams can become polarized on an issue in ways that do not reflect the full range of information and opinion in the group. As team members compare their positions on an issue with those of others on the team, pressures emerge to accept one position or the other as the team position. Furthermore, when one position is more forcefully argued than another, it gains support, despite initial discussion that revealed no clearly favored argument (Cartwright and Zander, 1968).

A manifestation of the poor use of information is the groupthink phenomenon, which can lead to premature convergence on a poor decision (Janis, 1972). The concept emerged from Janis’s studies of high-level policy decisions by government leaders, including decisions about Vietnam, the Bay of Pigs, and the Korean War. Groupthink can occur at all levels of decision making, from the level of a family to high-profile policy decisions. Essentially, groupthink occurs when the desire for harmony and consensus overrides members’ rational efforts to appraise the situation. In other words, groupthink occurs when maintaining the pleasant atmosphere of the team implicitly becomes more important to members than reaching a good decision. Some or all of the following symptoms may indicate the presence of groupthink (Janis, 1972):

1. The illusion of invulnerability. Team members may reassure themselves about obvious dangers and become overly optimistic and willing to take extraordinary risks.

2. Collective rationalization. Teams may overlook blind spots in their plans. When confronted with conflicting information, the team may spend considerable time and energy refuting the information and rationalizing a decision.

3. Belief in the inherent morality of the team. Highly cohesive teams may develop a sense of self-righteousness about their role, making them insensitive to the consequences of decisions.

4. Stereotyping others. Victims of groupthink hold biased, highly negative views of competing teams. They assume that they are unable to negotiate with other teams, and rule out compromise. This refusal to compromise is also related
to their belief in the inherent morality and “rightness” of the team, as described above.

5. **Pressures to conform.** Group members face severe pressures to conform to team norms and to team decisions. Dissent is considered abnormal and may lead to formal or informal censure or punishment.

6. **The use of mindguards.** Mindguards are members who withhold or discount dissonant information that interferes with the team’s current view of a problem and its solution.

7. **Self-censorship.** Teams subject to groupthink pressure members to remain silent about possible misgivings and to minimize self-doubts about a decision. This and other symptoms are particularly prevalent when a team has a member with a great deal of power and influence.

8. **Illusion of unanimity.** A sense of unanimity emerges when members assume that silence and lack of protest signify agreement and consensus. Lack of disagreement does not necessarily mean there is not serious disagreement.

The consequences of groupthink are that teams may limit themselves, often prematurely, to one possible solution and fail to conduct a comprehensive analysis of a problem. When groupthink is well entrenched, members may fail to review their decisions in light of new information or changing events. Teams may also fail to consult adequately with experts within or outside the organization, and fail to develop contingency plans in the event that the decision turns out to be wrong.

Team leaders can help avoid groupthink. First, leaders can encourage members to critically evaluate proposals and solutions. Where a leader is particularly powerful and influential (yet still wants to get unbiased views from team members), the leader may refrain from stating his or her position until later in the decision-making process. Another strategy is to assign the same problem to two separate work teams. Most importantly, groupthink can be avoided by proactively engaging in a process of **critical appraisal** of ideas and solutions, and by understanding the warning signs of groupthink. Managers might also consider alternative systematic methods of decision making that emphasize member participation. **Nominal group technique** and **Delphi technique** elicit group members’ opinions prior to judgments about those opinions. These and other approaches help generate ideas, and facilitate objective debate (Delbecq et al., 1975; Edmondson, et al., 2003).

### Team Learning

In a changing and uncertain world, a team’s ability to learn is essential to its ongoing effectiveness (Edmondson, 1999). In the organizational literature, some discuss learning as an outcome, others as a process (see Edmondson, 1999). This chapter joins the latter tradition in treating team learning as a process, and we describe the behaviors and activities through which teams learn. Team learning is defined as an iterative process of reflection and action through which teams may discover and correct problems and errors in their work processes.

Learning processes consist of activities carried out by team members through which a team obtains and processes data that allow it to adapt and improve. Examples include seeking feedback on how well the team’s outputs meet its customers’ needs, talking about errors, and experimenting. It is through these activities that teams detect changes in the environment, better understand customer requirements, develop members’ collective understanding of the situation, or discover unexpected consequences of previous team actions.

A study of cardiac surgery operating room teams learning to use a new technology for minimally invasive surgery found that the teams that were successful did a great deal more reflecting aloud on what they were learning, on how the process was going, and what changes might be made going forward than other teams (Edmondson, 2003). The learning for these teams involved acquiring knowledge and skill related to technical aspects of the new technology. It also involved practicing new interpersonal behaviors, such as speaking up in the operating room in new ways.

The behaviors through which teams learn involve interpersonal risk for individuals. For instance, other team members may think less of an individual for raising a concern, admitting an error, or asking a question for which the answer seems obvious to some. For this reason, learning in teams is greatly enabled by a climate of psychological safety, in which people believe that others will not think less of them for well-intentioned risks. This is an element of team climate, and is described further later in this chapter.

In health care, team learning is particularly important for two reasons. First, medical knowledge is constantly developing; individual providers must keep up with new care protocols, medications, and technologies. Physicians keep up with new developments in biology and medical technology by scanning
the medical literature, attending conferences, and consulting with trusted colleagues. In fact, developments in science and medicine have always required continuing education for physicians and nurses. At the same time, however, the organizational context of health care delivery has changed in ways that increase the interdependence of the care delivery process, so that groups must learn how to better coordinate their activities to reflect changes in care protocols and to adjust to the unexpected. One recent study of teams, mentioned above for its findings related to psychological safety, also found that quality improvement teams had greater success implementing new practices when they had found support in the medical literature for the efficacy of the proposed changes (Tucker et al., 2007).

Another vital element of team learning in health care is the detection and correction of error. One way this learning occurs is through Morbidity and Mortality (M&M) rounds; however, physicians are often uncomfortable openly discussing errors with their colleagues, such that much learning about error remains private and individual. The current medico-legal environment, which holds the individual accountable for medical outcomes, together with the ethic of professional conscientiousness, serves to reinforce a model of learning focused on private learning by individual practitioners (Bohmer and Edmondson, 2001). Yet, team learning, where new insights are rapidly shared among providers, is a critical part of the new environment of health care, and increasingly, health care organizations are learning how to learn from their own failures. For example, Children’s Hospital and Clinics of Minneapolis instituted “blame-free reporting” and safety action teams to encourage the reporting of mistakes and near misses to learn how to prevent them. Intermountain Health Care in Utah uses an integrated system that blends information technology and behavioral norms to allow the hospitals to learn from error and continuously improve the quality of care (Bohmer and Edmondson, 2002; Edmondson, 2004). Recently, Cincinnati Children’s Hospital has embarked upon a similar and highly successful change effort, in which errors and sentinel events are thoroughly analyzed and publicly discussed for the lessons they contain (Tucker and Edmondson, 2009). In these cases, managers have worked hard to help people overcome the stigma of error, for the purpose of continuous, collective learning.

**Stages of Team Development**

The effectiveness of a team is affected to varying degrees by its maturity, or stage of team development. Teams go through predictable stages of development, although the speed with which they mature varies. The familiar model presented below suggests that teams progress through five stages (Tuckman, 1965; Whetten and Cameron, 1998). Every team may not follow this precise pattern, but maturity and the age of a team need to be taken into consideration as a team leader plans and works. The following sequence of team development is summarized below:

1. **Forming.** During the first stage, members become acquainted with each other and with the team purpose. Members attempt to discover what behaviors are acceptable and unacceptable, while establishing trust and familiarity. This early stage is characterized by polite interactions and tentative interactions. Establishing a clear direction is critical.

2. **Storming.** At this stage, the team is faced with disagreement, counter-independence, and the need to manage conflict. Members may attempt to influence the development of group norms, roles, and procedures; therefore, the stage has high potential for conflict. Focusing on process improvements, team achievement, and collaborative relationships can help overcome emergent conflicts.

3. **Norming.** During this stage, the team grows more cohesive and aligned in purpose and actions. Agreement on rules and processes of decision making, roles and expectations, and commitment emerges. Emphasizing the team's direction or goals is essential for forward progress.

4. **Performing.** Once team members agree on the purpose and norms of the group, they can move forward to the task of defining separate roles and establishing work plans. The team is faced with the need for continuous improvement, innovation, and speed. Leaders must be ready to sponsor new ideas, orchestrate their implementation, and foster extraordinary performance from members.

5. **Adjourning.** For temporary teams, the adjournment stage is characterized by a sense of task accomplishment, regret, and increased emotionality.

As noted, teams may deviate from this model; not all teams pass through all stages as described. Some teams may begin at a norming or performing stage (e.g., members that have worked together before), while some may never move beyond the storming stage. Moreover, teams may not move in a linear fashion through the stages, but exhibit long, stable periods in which little occurs interspersed with relatively brief periods of dramatic progress—a “punctuated equilibrium” model...
Gersick, 1989). Finally, some teams may revert to earlier stages of development, sometimes resulting from new tasks or responsibilities given to the team, a change in formal or informal leadership, the addition of a new member, or the loss of a valuable member. Managers should consider the stage of team development in establishing team expectations. For example, research has shown that managers of virtual teams need to know the challenges associated with each stage of the life cycle and time appropriate intervention strategies accordingly (Furst et al., 2004). An example of such a strategy is the active involvement of a senior sponsor in clarifying team mission and goals during the early stages of team development.

**Team Processes as Intermediary**

Team processes are thus the intermediary between team structures and the outcome of team effectiveness. Through ineffective processes, teams composed of highly talented individuals can be dysfunctional. Conversely, effective processes allow the team to achieve its potential. Team processes are important because unlike relatively unchangeable inputs, such as the team’s composition and task, team processes can be altered and improved upon by team members and leaders. Teams can learn how to better communicate, leaders can improve their ability to manage meetings and coach other team members, team members can experiment with different types of decision making, and teams can learn and improve. The extent to which these and other processes are appropriately used can have a profound impact on team outcomes.

Finally, what constitutes effective team processes is contingent on the context. As noted above, saving lives in an emergency department requires extraordinary and rapid communication, and a unilateral decision-making style, while a medical research team can benefit from a participative consensus-seeking approach. In sum, no single set of team processes meets every team’s needs; team processes are dependent upon structural aspects of the team, including team size, the nature of team tasks, and the larger context within which the team operates.

**DEBATE TIME: The Individual versus The Team?**

Managers often preach the importance of teams, yet our workforce management systems continue to be oriented largely on the individual. If teams are that important, shouldn’t we reengineer our workforce management practices around teams rather than individuals? Consider the following aspects of management:

- Individual employees are given a job description, and this job description is often supported by a comprehensive job analysis. Teams, on the other hand, often have vague goals and unclear work processes.

- Individual employees are provided with an orientation to their job and ongoing training to improve their performance. How often are teams provided with a similar orientation to their work and training to improve team performance?

- Complex systems have been established to select job applicants for work in an organization. With some exceptions, technical qualifications are deemed to be of paramount importance in the selection process. Systematic evaluative techniques are used to assess technical qualifications. If organizations are truly interested in improving team performance, should we not employ similar methods to determine the “team-worthiness” of job applicants?

- Organizations orient their motivational and reward systems around individual employee performance. Given the importance of teams and team performance, should we not spend energy developing effective ways of motivating and improving team performance?

- Performance management systems are designed to provide feedback, coaching, and goal setting for individuals. How often are teams provided with feedback on their performance, along with strategies for improving team performance?

The question is not whether we should ignore the individual and individual reward systems. The larger question is how do we design the workforce management process in our health care organizations to truly do justice to the prominent role of teams, now and in the future? Can our culture change from one that views the individual as the sole unit of value to one where the work team is recognized as having similar value? Is it possible for our bureaucratic organizational systems—such as personnel systems—to recognize and accommodate the value of teams? Are the obstacles insurmountable: is it worth the effort?
CONCLUSIONS

One of the most important managerial tasks in health services organizations is the development and management of teams. It is now common wisdom that organizations as a whole, as well as individuals, are dependent upon well-functioning teams. As noted, however, teams do not naturally perform optimally. Teams must be set up and led, if they are to succeed. Nor do teams naturally develop and improve. In fact, their level of performance may even erode and become dysfunctional over time without deliberate and continuous supportive efforts. Effective managers understand that improving a team’s performance is a complex endeavor and that improvement strategies need to emphasize both design—structure and process—and understanding of the challenges and contributions of individual members of the team (see Debate Time). Finally, while we can make general theoretical statements about teams, each team develops in a distinct way, at its own pace, making its own mark in the organization. Thus, there is both science and art to managing and working with teams.

SUMMARY AND MANAGERIAL GUIDELINES

Effective team management requires understanding of fundamental team principles and theories as well as an ability to translate those concepts into management action and behavior. The following managerial guidelines provide specific applications of theory with the goal of improving team effectiveness:

1. Team members are both individuals and team members. To ensure a sustained level of motivation, reward systems should be constructed so that individual and team contributions are recognized.

2. Ongoing teams usually have a set of group norms, some of which are functional and others dysfunctional. Team leaders need to be aware of both positive and negative norms, and develop strategies to reinforce positive norms and eliminate norms that limit team effectiveness.

3. Conflict is common in teams, and managers must be able to accurately diagnose the causes of conflict. To resolve team conflict, managers should also be comfortable with a range of conflict resolution strategies.

4. Team leadership is complex, partly because teams often have both a formal leader as well as one or more informal leaders. Managers should be aware of these often unspoken dynamics because they can have a profound impact on team processes and effectiveness.

5. Managers should clarify to team members the role of a team. In particular, team members need to understand clearly the team’s role in decision making. Some teams provide input to decision makers, while other teams have the authority to make decisions. Team leaders should clearly understand the decisional authority of the team, and communicate this accurately to team members.

6. Managers should understand the applicability of a variety of approaches to building team consensus and decision making. They should avoid prematurely moving to arbitrary approaches to decision making, such as imposing a decision or voting. Full airing of perspectives, and the identification and discussion of team members’ interests (rather than positions) may help to identify areas of agreement among team members.

7. Managers should be aware of status differences among team members and how these differences may affect the fullness of discussion and the airing of differences.
8. Managers should employ specific techniques for managing meetings, including:
   a. Team leaders should prepare an agenda, with time limits for each item, and the placement of the most critical agenda items early on the agenda. Some managers include an indication of the purpose of each item, whether it is for information, discussion, decision making, or other purpose.
   b. If a specific team member is expected to address an issue at a meeting, the manager should brief those individuals prior to the meeting to be sure there is agreement on the agenda item and the role of the team member during the meeting.
   c. Team leaders should review the progress made to date and establish the purpose of the meeting. When appropriate, ask subcommittee representatives to review the progress of their work to date.
   d. Team members should be provided with needed materials prior to meetings.
   e. Manage team discussions to ensure full participation. For example, it is advisable to ask more junior team members for their input prior to asking for the views of more senior team members.
   f. Keep a record of team deliberations, in particular decisions that were made and the discussion that supported each decision.
   g. Team leaders should utilize delegation for complex decisions and information-gathering tasks. Managers should maintain an awareness of the flow of discussion and close off discussion when it becomes apparent that further progress requires more information and/or more extensive analysis.
   h. Close the meeting by summarizing what has been accomplished and reviewing assignments for the next meeting.

DISCUSSION QUESTIONS

1. To foster teamwork and a culture of quality improvement, a new director of an ambulatory care center in a hospital has begun holding twice-monthly management team meetings, consisting of several physicians, nurses, physician assistants, financial managers, and others. Attendance at these meetings has been erratic, and enforcing attendance is difficult because many of these people report to their discipline chiefs rather than to the director of the center. What advice would you give to this person to promote more consistent participation?

2. A community task force has been formed to improve the coordination of care for the frail elderly. Given the large number of people and agencies involved in providing services to this population, how would you balance the need for representation with the need to keep the task force size to a manageable level?

3. You are a member of a hospital project team assigned to develop a new pediatric oncology service line. Your team is expected to develop a business plan for presentation to the senior management team and the hospital board. A specific timetable has been established for producing a set of deliverables. The team leader is a well-known oncologist with a very strong clinical background and reputation. However, his team leadership skills leave something to be desired. Among other problems, meetings are cancelled at the last minute, delegation of tasks is ambiguous, and the focus and direction of the project changes scope at virtually every meeting. As a team member, what alternatives do you have to improve team management? Which alternative would you select as having the best chance of success?

4. Along with other hospital business managers, you have been a member of a management team. Recently, you have been promoted, and your former business manager team members now report to you. As the new leader of the management team, what challenges will you face in managing the team? How would you approach these challenges?

5. As described in this chapter, teams go through stages of development. As a team leader, what is the practical value to understanding these stages? How could this knowledge improve your effectiveness as a team leader?
CASE: Using Teams to Achieve Millennium Development Goals

Childhood mortality continues to be a major health problem in developing countries. A child born in a developing country is over 13 times more likely to die within the first five years of life than a child born in an industrialized country. Sub-Saharan African countries account for about half the deaths of children under five in the developing world. Between 1990 and 2006, about 27 countries—the large majority in sub-Saharan Africa—made no progress in reducing childhood deaths.

The country of Ghana has set a goal of decreasing childhood mortality from 110 per 1,000 live births to 20 per 1,000 live births by 2015. The most common causes of death among children under age 5 in Ghana are malaria and neonatal diseases, primarily asphyxia, sepsis, and prematurity. Tragically, most of these deaths are preventable. Among other initiatives, Project Fives-Alive! was established to reduce childhood mortality in Ghana. The approach being taken by this nationwide project is the Institute for Health Improvement (IHI) Breakthrough Series Improvement Collaborative Network. Through this multiyear project, teams of frontline health providers and their managers meet periodically in learning sessions where they acquire quality improvement knowledge and skills. Teams test system improvement changes, and learn from each other. This is one of the first applications of IHI improvement initiatives in Africa. When the project is fully scaled up, over 1,000 teams will have participated in this improvement effort.

Among the most important factors associated with under-five mortality is underutilization of health services. For example, many women do not receive antenatal care, preventive measures (such as neonatal tetanus protection and folate/iron supplements) are inconsistently provided, and many women lack knowledge about oral rehydration therapy and other life-saving procedures.

Why the focus on teams? The answer is that frontline providers are often in the best position to understand the obstacles that women face in accessing services—and to suggest and test potential solutions. As with quality improvement initiatives elsewhere, teams need training, knowledge, and skills, as well as a framework for applying quality improvement methods. Throughout the country, teams are being trained in quality improvement methods: setting measurable goals, implementing tests of change, identifying best practices, and—perhaps of greatest significance from a country development perspective—sharing their experiences with other teams and disseminating this knowledge to the larger global health community.

Results are encouraging. Teams are enthusiastically sharing their knowledge through collaborative meetings, and evidence is emerging of improvements in the processes of care, and hopefully, in health outcomes. Even more encouraging is evidence that teams are learning how to function as teams, and to apply a systems improvement perspective to other health system problems. Development of well-functioning and highly trained teams could be a key part of achieving important global health goals.

Questions

1. One feature of the teams in this case is frequent turnover among team members. How might turnover among team members affect team performance? What approaches can team leaders take to minimize potential negative impacts of turnover and gain advantages, if any?

2. Consumers or patients are sometimes involved in quality improvement teams, but in this role, they may feel that their voices are unimportant, or that their participation is symbolic rather than substantive. Do you think that consumers should be involved in the improvement teams in this case? Why or why not? If consumers are involved, how can team leaders and members most effectively utilize their knowledge and insights?

3. Even when team improvement efforts achieve change, the sustainability of change remains a pervasive challenge. In fact, sustainability of the teams themselves may be problematic. What are the particular obstacles to sustaining the improvements achieved by teams in this case? Similarly, what factors might lead to the dissolution of the improvement teams over time? As a team leader, what strategies might be used to sustain change and to uphold the vitality of the team over time?
REFERENCES


CHAPTER OUTLINE

- Who Says What to Whom?
- Barriers to Communication
- Stakeholders
- Tools for Managing Organizational Communication
- Social Networks and Social Media
- Communication Networks
- Organizational Politics
- Communication as a Leadership Art

LEARNING OBJECTIVES

After completing this chapter, the reader should be able to:

1. Understand the classical sender-receiver communication model and later elaborations of it
2. Identify stakeholders and choose the means for effectively communicating with them
3. Describe the most recent research on social networks and apply it in their work settings
4. Appreciate the importance of organizational politics
5. Recognize the importance of effective communication in leading health care organizations
KEY TERMS

Barriers to Communication
Communication Networks
Curse of Knowledge
Distortion
Ethos, Pathos, Logos
Feedback
Leadership
Message
Organizational Learning
Organizational Politics
Patient-Centered Communication
Receiver
Sender
Social Media
Social Networks
Speaker-Listener Model
Stakeholder
Stakeholder Analysis

IN PRACTICE: The Debate over Health Care Reform

At a meeting of the American Medical Association (AMA), in June 2009, President Barack Obama addressed a group of the most influential doctors in the country about health care reform (Text: Obama’s Speech on Health Care Reform. June 15, 2009). Many people in the audience were skeptical about his plans. Seeking to win them over, the president emphasized a few key points:

- The health care system needs better record keeping. The government should therefore continue investing in electronic medical records. Better records, he claimed, will lead to “lower administrative costs” and “reduce medical errors.”
- Americans need to take more responsibility for their own health. They need to quit smoking, go for a run, and encourage their kids to turn off their video games and spend more time playing outside.
- Everybody needs to eat better and swear off the fatty foods that cause obesity. To show he was following his own advice, the president told the doctors he had planted a vegetable garden on the White House lawn.
- Employers should adopt incentive programs like Safeway’s. Safeway has a program called “Healthy Measures” that offers rewards, in the form of reduced premiums, for lowering cholesterol levels and blood pressure.

The payoff of these reasonable proposals, claimed the president, is that consumers can reduce the dollars they spend on medical care, make fewer unnecessary visits to their doctors and the hospital, and be healthier. President Obama made it clear that even the doctors in the audience would benefit, too. Research-based treatment guidelines will make their practices more effective, and the cost burden of the entire health care system will become more sustainable.

Sounds like a win-win. Who could object?

But people did—lots of them. Most notably, Sarah Palin, the Republican vice presidential candidate in the 2008 national election, almost singlehandedly derailed President Obama’s arguments for reform by raising the specter of “death panels.” Two months after the President’s AMA speech, Palin famously declared: “The America I know and love is not one in which my parents or my baby with Down syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society,’ whether they are worthy of health care. Such a system is downright evil” (Palin doubles down on death panels, 2009). Somehow, the president’s suggestions about invigorating jogs and home-grown vegetables were getting lost in the debate over reform.

Even though leading bipartisan policy analysts made it clear that the notion of death panels was fiction rather than fact, the image of somber dark-suited government officials making life-and-death decisions that affect powerless citizens was too gripping to be forgotten. By the end of August, most news outlets were treating the “death panel” question as one of the central issues in the reform debate.
CHAPTER PURPOSE
Disregard, for the moment, the political jockeying that went on in the public debate over death panels. The debate serves to highlight an essential characteristic of health care information: for technical as well as political reasons, it is astoundingly complex. The complexity is a problem for any professional in communicating about issues related to clinical delivery, financing, outcomes, safety, professional expertise, and patient choice. Whether you are a politician advocating a policy, an administrator managing a hospital, or a physician treating a patient, it is likely that at least some part of your message—the information or feeling you seek to communicate—will be misunderstood.

The purpose of this chapter is to review the communication concepts and frameworks you can employ as an executive or health care provider to avoid this unfortunate outcome. By applying the key concepts described in this chapter, you will increase the chances that you actually get your point across. You will learn:

1. How to think about the act of communication.
2. The theory and practice of managing stakeholders—the people and groups who have an interest in your ideas.
3. The science of relationships and its practical value in health care settings.
4. The importance of organizational politics and how to lead in complex political environments.

WHO SAYS WHAT TO WHOM?
One of the dominant figures in communication theory is the ancient Greek philosopher Aristotle (2006). His model of communication, which he called “rhetoric,” has influenced the way theorists have thought about the topic for over 2,000 years. Aristotle described communication as a mostly linear process involving a speaker and a listener—the speaker-listener model. Figure 6.1 shows a simplified version of this process. Effective speakers “package” their message using one or more of the three persuasive means of conveying a message: ethos (character), pathos (emotion), and logos (logic).

Aristotle’s means of persuasion are still relevant today. Consider, for example, the enduring importance of character—or “credibility,” in modern terms. People tend to believe facts stated by someone whom they see as trustworthy or

Figure 6.1 Aristotle’s Means of Persuasion.
knowledgeable and discount information coming from those whom they mistrust. Indeed, character often trumps logic, as you can see in most political debates. Whether or not you worried about death panels probably had a lot to do with your political leanings: Palin supporters were more likely than others to be suspicious, simply because it was she who had raised a concern about government bureaucrats making life-and-death decisions. Similarly, since people have especially strong reactions to emotion, it is an especially powerful way of making a point—often more powerful than logic alone. Just consider the recent examples of Ronald Reagan or Bill Clinton, who are considered masters of using stories and emotional appeals to win support for complicated policies. But emotion is not always enough. Logic matters most when someone is really paying attention to your ideas. Psychologists have identified a principle called “the power of because,” which refers to the fact that arguments backed by logic or reasons tend to be more persuasive than those for which the speaker offers no supporting evidence (Langer, 1989).

The well-known management theorist Nitin Nohria captured the importance of rhetoric and persuasion for modern leaders in a widely cited quote: “Communication is the real work of leadership” (Blagg and Young, 2001; Eccles, Nohria, and Berkely, 1994; Nohria and Harrington, 1993). The most effective leaders, Nohria says, know how and when to use each of Aristotle’s means of persuasion. Most important, they listen and observe carefully before they communicate, paying attention to social clues that reveal the underlying interests and values of a particular audience: middle managers, front-line staff, external groups, and others. Effective leaders recognize that communication is more than “just words.” As the philosopher and linguist C. W. Morris said, language is the “subtlest and most powerful tool” for controlling behavior (Morris, 1949). Modern corporate leaders such as General Electric’s former CEO Jack Welch and Apple’s CEO Steve Jobs have a deep appreciation for this point, crafting and rehearsing their public statements with the utmost care.

Recent communication theorists have built on Aristotle’s speaker-listener model, adding an element that Aristotle only implied: distortion. The sociologist Harold Laswell, in summarizing his perspective on communication, famously asked: “Who says what in which channel to whom?” (Laswell, 1948). Laswell recognized that many factors affected how listeners understood a message: the sender of the message, the content of the message, the medium (face-to-face, written, or electronic communication), and the listeners themselves. All of these factors influence “impact,” which might be completely different from the literal or intended content of a message (Croft, 2004). Later scholars went further and incorporated this possibility of misunderstanding into their theories, leading to the more complex “feedback” model illustrated in Figure 6.2 (Longest and Young, 2006).

The feedback model takes account of psychological, cognitive, and contextual factors in communication. From a practical perspective, it shows that you need to pay attention not only to your intended meaning, but also to the entire context in which communication takes place and which ultimately determines how your meaning is construed.

The philosopher of language Ludwig Wittgenstein underscored the centrality of context and the likelihood of misunderstanding in a brief, provocative quote that has stimulated decades of discussion: “If a lion could speak, we could not understand him” (Wittgenstein, 1973). Basically, Wittgenstein’s insight is that to communicate effectively, you have to understand the other’s situation: their history, social context, values, and psychology. There is no way a human can understand a being so utterly different as a lion. By extension, if another person’s values and experience differ dramatically from yours, you will have a hard time communicating with them. The practical implication, for managers and leaders, is that they need to understand the context in which others hear
their social networks, and the organizational politics that represent their interests. Skillful executives know that they must actively manage stakeholders, tailoring messages to their context and cultivating their support for policies and programs. Otherwise, even the best plans will encounter resistance that slows down or derails execution.

BARRIERS TO COMMUNICATION

Even when you, the sender, know exactly what you want to say, the distortion within the receiver often blocks your message. As George Bernard Shaw quipped, “The single biggest problem in communication is the illusion that it has taken place.”

A game created at Stanford University shows why it is that communication so often goes awry. A researcher assigned people two roles: “tappers” and “listeners.” Each tapper was asked to tap out a well-known song to a listener. Before this exercise, the tappers were asked to estimate the odds that the listener would recognize the song. The average reply was 50 percent. In actuality, only 1 in 40 listeners recognized the song. The explanation is that the tappers have trouble imagining what the listeners are hearing. The songs seem obvious to the tappers, but to the listeners, they are anything but. The tappers suffer from the Curse of Knowledge—the problem of imagining another person’s state of mind when you have a piece of knowledge that they lack (Heath and Heath, 2007).

The consensus among contemporary scholars is that today’s leaders need to engage in robust, targeted two-way communication. The era of autocratic, top-down communication is over. Markets and consumer preferences change so fast that organizations must be constantly learning and adapting to internal and external environments. Leading management theorists use the term organizational learning to describe the range of communication methods designed to engage people in a collective process of problem solving, planning, and implementation (Senge, 2006).

Each audience is a stakeholder—a person or group of people who are affected by your ideas and will have a reaction to them. The full context in which they live and work encompasses their psychological and cognitive biases, their social networks, and the organizational politics that represent their interests. Skillful executives know that they must actively manage stakeholders, tailoring messages to their context and cultivating their support for policies and programs. Otherwise, even the best plans will encounter resistance that slows down or derails execution.

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<thead>
<tr>
<th>Purpose</th>
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<tr>
<td>Manage Public Relations</td>
<td>Employees, Media, Analysts</td>
<td>Press releases, Interviews</td>
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<td>Build Internal Support for Initiatives</td>
<td>Employees</td>
<td>Town Hall Meetings, Memos, Newsletters</td>
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<td>Marketing</td>
<td>Physicians, Consumers, Payors</td>
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<td>Government Relations</td>
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</table>

Figure 6.3 Organizing a Communication Strategy.
When a CEO announces that his or her hospital generated $200 million in annual profit, many of his or her listeners, no matter how educated or sophisticated they might be, imagine that the sum is tidily stored in a bank account somewhere. Some will complain that if the hospital “made” so much money, they should get some of it. Only those who have experience working with income statements or have an MBA degree really understand that profit is actually an accounting concept and not a pile of dollars waiting to be spent. Physicians, nurses, and technical specialists are trained in clinical settings, so their frame of reference makes it difficult to understand the practical import of the CEO’s message about operational performance. A similar problem occurs in clinical encounters, where misunderstandings are surprisingly common. There is evidence that patients misunderstand up to 80 percent of the information conveyed by their physicians (Britten et al., 2000). Uncertainty, anxiety, and lack of clinical training all get in the way.

Extensive research has revealed that one typically encounters a small number of barriers in communicating a message (Shell and Moussa, 2007). As an organizational leader, to increase the likelihood that important stakeholders will pay attention to you and your idea, you need to assess each situation, decide which barriers are relevant, and employ strategies to turn them into assets. There are five barriers: negative or ambiguous relationships, poor credibility, conflicting belief systems, conflicting interests, and communication mismatches. By systematically planning to turn the barriers into assets, you help yourself imagine what it is like to view a situation from a stakeholder’s perspective and how to communicate your message to them. This is the best way to overcome the Curse of Knowledge.

Relationships
Developing relationships is a fundamental skill in managing and leading health care organizations and in delivering clinical treatments. Relationships give people a level of trust and confidence in each other, facilitating communication and making it easier to cooperate. People respond well to others who take an interest in them, especially when there is no obvious benefit that flows from it.

Even in today’s wired world, where you can communicate using e-mail, Twitter, Facebook, and many other social media, face time matters in building relationships. In a 1987 experiment, R. F. Bornstein and two other psychologists showed that, in the most literal terms, a face makes all the difference (Bornstein, Leone, and Donna, 1987). They flashed photographs of several people on a screen so quickly that subjects were not even aware of having seen them. Then the subjects had conversations with the people whose photographs had been displayed. Consistently, subjects found those people “likeable” and, even more striking, persuasive. In staged disagreements, subjects sided with them more often than with others they had never seen before.

Similarly, in clinical settings, many patients who value relationships need to feel the connection that comes with a face-to-face encounter. As one patient put it, “I think that if I meet a new doctor and we don’t have that face-to-face contact, I would not feel comfortable telling him all my ills” (Armstrong-Cohen, 2009). The following true story about an elderly patient vividly illustrates this preference. One morning, he was touching up the paint on his sailboat. Nearby, another boat owner, who happened to be an emergency medical technician, noticed the man was struggling to breathe and that his lips had turned purple. A trip to the local community hospital led to a barrage of high-tech tests and procedures, a diagnosis of emphysema, later complications with cerebral hematomas, and hospitalizations and re-hospitalizations that brought him into contact with a neurologist, a neurosurgeon, a cardiologist, and a pulmonologist. Throughout this medical ordeal, the team of specialists stayed in touch with each other and the primary care physician via various electronic media. But one person remained out of the loop—the patient. One day, six months into the experience, the primary care physician phoned his wife to check on his patient. The patient recalls thinking, “Why was he calling her?” The physician was communicating, but he was emotionally disconnected. He was not paying enough attention to the relationship. Feeling intense frustration, the patient was likely to ignore some or all of the physician’s prescriptions, even if he understood them in the first place.

Because of the importance of relationships, you should take the time to get to know what is important to the people you work with. Successful stakeholder management depends upon your ability to establish, maintain, and deepen your connections with people.

Credibility
As Aristotle first noted, credibility ensures that people take you and your ideas seriously. Most modern experts agree that credibility is based on others’ perceptions of three
characteristics: competence, expertise, and trustworthiness. Thus, your credibility resides in a subjective experience that others have of your character rather than your objective qualities. Moreover, credibility is highly fragile. You can lose your credibility in a single moment of poor judgment, miscalculation, or misconduct.

You establish competence by reliably making good on your commitments. When you promise that a department chair will receive another assistant professor position, you should be sure you can actually follow through on the pledge. In health care organizations, agreements big and small hinge on reliability. Once you gain a reputation for it, your words carry tremendous weight.

When it comes to expertise, you must choose your sources carefully. You may consider your experience as an administrator to be an important source of authoritative knowledge, but the surgeon you want to influence may consider administration to be simply applied “common sense.” In this case, you must find some other way of establishing your credibility. In beginning a conversation, you may need to acknowledge that the surgeon’s expertise is extremely valuable to the success of the hospital. This shows that at least you know enough to value his or her efforts. As Dale Carnegie pointed in his classic How to Win Friends and Influence People, the need to feel important is one of the most powerful desires that everyone has.

Management expert Stephen Covey says that trust is “the one thing that changes everything” (Covey and Merrill, 2008). With it, almost any stakeholder can be won over. Without it, you have a hard time getting anything done. In a study of 15 top business leaders of the past 20 years, researchers discovered that the most important skill they had was the ability to convey to others that organization interests always came before personal agendas, including their own (Harrison and Clough, 2006).

Beliefs
Whenever you can, you should couch your messages in terms that resonate with the core beliefs and values of your stakeholders. These deeply held principles exert a strong influence on their opinions and actions. Psychologists have a variety of explanations for why appeals to core beliefs work: belief bias (the tendency of people to accept any and all conclusions that fit within their systems of belief), the consistency principle (the need for people to behave in ways that are consistent with previously declared values and norms), and the pull of “power” or “God” terms (the tendency of people to respond to appeals invoking ultimate values such as safety, connection, community, or truth). These explanations all point to the same conclusion: if an idea promises to reinforce one of your stakeholder’s core beliefs or the values related to them, the idea gains traction (Gardner, 2006).

Surprisingly, this phenomenon affects researchers as well as dogmatic ideologues. For example, in the historic effort to map the human genome, virtually everyone in the scientific community believed that a painstaking, gene-by-gene mapping process, destined to take decades, was the only way to assure a complete, accurate map. When geneticist James Weber and computational biologist Eugene Myers made a landmark presentation at a 1996 conference in Bermuda outlining a “shotgun sequencing” method for speeding up the process, leading scientists refused to take it seriously. “Flawed and unworkable,” said the experts. But one man—a little known researcher and former surfer named Craig Venter—was not so sure. He called Myers, and together they made history, turning the human genome mapping effort into a high-profile race that they won a short four years later in 2000.

The inventor of the theory of evolution, Charles Darwin, once remarked that it was so difficult for him to overcome his own beliefs when he was gathering data that he made a conscious effort to seek out contrary examples. The temptation to skip over evidence that contradicted his beliefs was so strong that Darwin made a habit of immediately writing all such evidence down. Otherwise, he reported, he was sure to forget it.

If even committed scientists have trouble overcoming the biases caused by their own beliefs, imagine the problems such beliefs cause in ordinary organizational life. Under such circumstances, it will not matter how much formal authority you may have as an executive or department administrator. Ideas that violate basic beliefs will simply be rejected. Because belief bias is so powerful, you should frame your ideas using key phrases that honor your stakeholders’ core values. In the health care setting, such phrases include “quality care,” “patient satisfaction,” “scientific rigor,” and “outcomes.” Hot-button phrases likely to stimulate resistance are “bottom line performance,” “market-based competition,” and “efficiency.”

When you advocate an idea that seems contrary to some core belief, you should break your proposal into small bites that reduce the amount of dramatic change required from your stakeholders. Psychologists have discovered that people
sometimes have what they call “anchor positions” on various beliefs and opinions, and their willingness to be flexible on these positions can depend on how much they are asked to change. The less you ask of your stakeholders, the more willing they are to move in your direction.

Another example from the research world illustrates this point. In the early 1980s, it was hard for anyone in the IBM research department to get a hearing for ideas that took personal computers seriously. Senior leaders believed that there were no competitive markets left to conquer. IBM was so dominant that the only measure of real success left to them was promotion within the company. Low-level internal task forces had forecast that the industry was about to change, but the people at the top, blinded by their beliefs, refused to take these warnings seriously. Nevertheless, an IBM senior manager named Bill Lowe succeeded in obtaining development funds for an experimental PC project that set the stage for IBM’s entry into that market. He did it by keeping the project so small nobody could be bothered to oppose it. When it became clear that Lowe’s little program would take no resources away from the focus on the company’s corporate customers, the IBM Management Committee let it pass as one of the dozen or so things it approved in a given week. The PC initiative, in short, flew in under the radar screen of IBM’s core beliefs.

**Interests**

At the very center of stakeholder management, like the bull’s eye in the middle of a target, are their self-interests, problems, and needs. If you can show your stakeholders that your idea furthers their interests, you will usually have a much easier time gaining their support.

Academic studies in psychology confirm two important findings about the role of self-interest in communication. First, people pay much closer attention to messages they see as having important personal consequences for them than ones that do not. Even a glance at nonfiction bestseller lists in publishing, which is perennially littered with titles such as *You on a Diet*, *Why We Want You to Be Rich*, and *Younger You*, confirms this basic truth. Second, self-interest biases the way people think about proposals. Naturally enough, people tend to favor ideas that benefit them and oppose those that will force them to shoulder significant costs. But research has also shown that audiences see arguments as more persuasive when they stand to gain from an idea and less persuasive when they stand to lose. In short, people’s interests serve as windows through which they see your ideas. When you can find and address their interests, they open their window to let your ideas in; if they see your idea as running against their needs, the windows close.

To think about your stakeholders’ interests in a systematic way, you should ask three important questions:

1. Why might it be in the other party’s interests to support my idea?
2. What do other parties want that I can give them to gain their support?
3. Why might they say no?

Your answers to these questions will help you frame your idea so that it appeals to others’ underlying interests and gets their attention.

For example, a medical center faced a serious crisis when a change in government regulations forced the hospital CEO to take away a major insurance benefit enjoyed by a low-paid but important group of workers: hospital residents (doctors in training). As the CEO prepared his formal announcement to make this change, rumors spread that the residents were organizing a job action to demand compensation to make up for the loss. The hospital, meanwhile, was in no position to give this group a raise without also raising the pay of many other workers, something it could not afford to do.

Finding himself between a rock and hard place, the CEO asked the residents’ leaders to join a committee to explore their overall situation at the hospital. His charge to the administrator leading this committee was simple: find out as much as possible about what the residents’ real interests were. His hope was that something would turn up that he could take action on. After a week of meetings, his administrator reported back that the residents would be willing to accept their reduced insurance benefit if the hospital would agree to one very important demand: they wanted to wear the same, somewhat longer white coats that full-fledged physicians wore so patients would treat them with the same respect. The CEO ordered the new coats without delay.

**Communication Styles**

Jim Collins wrote in his best-seller *Good to Great* that one of the best practices of the best organizations is a willingness to gather data, analyze it, and “confront the brutal facts”
(Collins, 2001). It sounds easy, but this advice is much easier to give than to follow. You must constantly remind yourself that your audience’s point of view is much more important than your own. And you need to return to the questions about your own credibility: How do stakeholders see you, and do you have credibility?

When it comes to communicating the substance of your message, the most important thing you can do is define it simply. Charles Kettering, the great engineer and inventor, stated: “A problem well stated is a problem half solved.” And according to noted communications expert David Zarefsky, “definition is the key to persuasion.” By providing a crisp answer to the question, “What is the problem?” you establish the context in which your ideas will be evaluated. Cognitive psychologists call this the act of framing, and it powerfully affects people’s perceptions, the standards they will call to mind, the evidence they will consider relevant, the emotions they will feel and the decisions they will ultimately make. As the American journalist and commentator Walter Lippman once said, “For the most part, we do not first see, and then define. We define first and then see.” How you state the problem defines what your audience will see in their mind’s eye.

At the World Economic Forum in Davos, Switzerland, in 2005, social activist Bono used framing to influence the AIDS debate. Bono sat on a stage with British prime minister Tony Blair, former U.S. president Bill Clinton, presidents Olusegun Obasanjo of Nigeria and Thabo Mbeki of South Africa, and Microsoft CEO Bill Gates. Bono listened as the others detailed all of the difficulties Africa faced in overcoming AIDS, poverty, and political corruption. Then the moderator asked Bono what he would like to see changed. Instead of continuing with the panel discussion, Bono decided to reframe the issue. What he wanted changed, he said, was “The tone of the debate.” He continued:

Here we are, reasonable men talking about a reasonable situation. I walk down the street and people say: “I love what you’re doing. Love your cause, Bon.” [But] I don’t think 6,000 Africans a day dying from AIDS is a cause. It’s an emergency. And 3,000 children dying every day of malaria isn’t a cause; it’s an emergency.

Bono’s message got through. The audience of corporate executives, government ministers, and cultural luminaries burst into loud applause. Poverty and AIDS in Africa were not business-as-usual issues for public officials. They were global “emergencies.” Emergencies require action, not analysis. They affect everyone, not just specialists.

To return to the earlier example of health care reform in the United States: the biggest mistake that the Obama administration may have made in managing communications on this issue is over-complication. As one critic put it, “the White House has taken an issue more intimate and immediate than perhaps any other in a voter’s life and transformed it into an abstract, technical argument about long-term actuarial projections. It’s a peculiar kind of reverse political alchemy: transforming gold into lead” (Pinkerton, 2010). Palin knew what she was doing when she adopted a different communication strategy. When asked about her “death panels” remark, she said: “[It’s] a lot like when President Reagan used to refer to the Soviet Union as the ‘evil empire.’ He got his point across. He got people thinking and researching what he was talking about. It was quite effective. Same thing with the death panels.” A follow-up comment reveals that she made a conscious choice in emphasizing the phrase: “The term I used to describe the panel making these decisions should not be taken literally” (Davis, 2009).

After simplicity, the second-most important quality of your message is vividness. Consider, for example, the strategy used in communicating the importance of hand washing at Cedars-Sinai Medical Center in Los Angeles (Dubner and Leavitt, 2006). Bacterial infections are a serious problem in hospitals, with thousands of people dying each year from germs carried from one patient to another on the hands of doctors and nurses. But getting hospital staff—especially physicians—to wash their hands after each examination is surprisingly difficult, even though everyone knows it is the right thing to do. Hospital hygiene poses, in short, a classic problem of organizational communication: getting people to adopt a new “best practice” when old habits are deeply ingrained.

At Cedars-Sinai, there were several causes for lax hand washing: physicians said they were too busy, the sinks were not always conveniently located, and, even more perversely, the doctors actually believed they were washing their hands. Each physician was convinced that “someone else” was the source of the bacteria problem. This presented administrators with a delicate issue of organizational politics: how could they sell doctors on the idea of washing their hands without insulting or alienating them? Administrators tried data-based, inspirational appeals using e-mails, faxes, and posters, but hospital staff assigned to spy on the doctors reported no
change in behavioral habits. The hospital then switched to the self-interest persuasion channel and offered doctors $10 gift certificates at the local coffee shop when they were seen washing up by hand-washing “spies.” This program had a moderately positive effect, but compliance still fell far short of what the hospital needed to protect its patients.

Finally, the hospital decided to try a vivid, visual way to deliver the hand-washing message. At a formal luncheon for the senior medical staff, the administrator in charge of the hand-washing initiative surprised everyone by bringing out a set of lab trays and asking the doctors to press their hands into these trays to record the bacterial cultures residing on their hands at that moment. The hospital used these hand prints to create full-color, graphic images of the bacterial colonies residing there. They made sure these pictures were as disgusting as possible.

Their final step was to transform these images into screen savers and load them on every computer in the hospital. Thus, no matter where physicians were, these images stalked them. Compliance with the hand-washing rule immediately shot up to nearly 100 percent and stayed there. The pictures of the actual bacteria on the doctors’ own hands, as Dubner and Levitt put it, “was worth 1,000 statistical tables.”

**IN PRACTICE:** Patient-Centered Communication

In a study sponsored by the National Cancer Institute, Ronald M. Epstein and Richard L. Street emphasize that communicating clinical health care information is much more than a matter of imparting objective information. Their model, illustrated in Figure 6.4, captures the distinctive factors that make communicating in this setting so challenging.

Notice that exchanging information is just one among six functions that clinicians need to manage in communicating with patients. Two of the others—responding to emotions and managing uncertainty—involves feelings both negative and positive: anxiety, fear, hope, and happiness. Another two aim at empowering patients to manage their own care and make appropriate decisions. The last one is about promoting health-inducing relationships between the clinician and patient and among family members and friends.

This model goes far beyond the linear sender-listener model that Aristotle created. Epstein and Street’s framework encompasses the full complexity of information, feelings, relationships, and high-stakes decisions that form the context of health care communication (Epstein and Street, 2007).

**Figure 6.4** Factors Affecting Communication in Clinical Care.

This story is an extreme example of a more general truth about human perception: people respond to ideas that are easy to visualize because they can be recalled from memory more readily. Psychologists call this the “availability” phenomenon. The more “available” an idea is, the more people believe it to be true. The beauty of the Cedars-Sinai screen savers was that the bacteria displayed actually had been found on the physicians’ hands.

**STAKEHOLDERS**

The “stakeholder” is one of the most important concepts in health care. Effective leaders know their stakeholders, paying close attention to the barriers that distort communication.

The concept of a stakeholder goes back to management research done in the 1960s about the environment in which corporate executives do strategic planning. Building on the idea of a “stockholder,” stakeholder theorists recognized that owners—the stockholders—were just one group among many that influenced a corporation’s decisions and actions. There were others who had legitimate or at least de facto “claims” on the corporation: customers, employees, citizens, legislators, and activists, to name a few. Each of these groups has an interest in a corporation’s investments, projects, environmental policies, and other commitments because they all have consequences that extend far beyond the narrow circle of profit-and-loss statements (Freeman and McVea, 2001).

Health care organizations are located in especially complex stakeholder environments. Take, for example, a large academic hospital. It can easily have more than two dozen stakeholders, as illustrated by Figure 6.5. Each stakeholder group has interests that predispose it to support or contest the hospital’s initiatives.

To understand stakeholder management in action, consider the quality initiatives that hospitals across the country have

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**Figure 6.5** Stakeholder Map for a Large Academic Hospital.  
recently undertaken. A centerpiece of many endeavors is unit-based clinical teams, composed of a physician, a nurse manager, and a quality specialist. These teams have produced stunning results, decreasing average length of stay, improving the effectiveness of care in a broad range of clinical areas, and reducing patient wait times for scheduled appointments. In the abstract, no one would claim that these are undesirable outcomes. Yet there may be reasons that certain groups might be lukewarm supporters, if not outright opponents, of quality efforts in specific situations. Physicians might feel, for example, that working in a team-based environment rather than the more traditional hierarchical structure in which they were trained compromises their professional status. Or unit staff might resist the introduction of new quality guidelines because they entail learning whole new ways of doing their jobs, with little or no benefit to be gained in compensation or job satisfaction. Other groups may have other reasons for opposing the initiative that, on the face of it, seem unassailable. As a hospital administrator championing the quality initiative, you would need to assess just who has a stake in it, whether they support or oppose it, and whether they have enough power to make a difference.

This is the essence of **stakeholder analysis**, which is the first step in stakeholder management. A useful tool to guide the analysis is a Power/Interest matrix, such as the one in Figure 6.6 (Block, 1991). By systematically mapping the stakeholders, you can begin to articulate communication strategies for each group.

This matrix reveals that you need to pay a lot of attention to those three people who are powerful and have a strong interest in

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**Figure 6.6** Power-Interest Matrix.

the initiative. Assume that two of them (Dr. Jones and Dr. Smith) are top-producing physicians—if they become unhappy, you had better respond quickly with some well-crafted message points. If there is one particular physician among them who wields influence with physicians across the hospital (Dr. Black), you should make a special effort to sit down with him or her and understand how you can address his or her concerns. You can adopt more of a maintenance strategy for those powerful stakeholders who have little interest in the quality initiative. The finance officers in departments that are not directly involved in the initiative fall into this category. Because of their position, they are generally powerful players, but they have no immediate reason to get involved. For the time being, you want to keep it that way, so you should make sure nothing happens to disrupt their peace of mind. As for those stakeholders who have an interest but wield little power, such as junior residents, you can communicate with them on a “need to know” basis. Finally, you can safely expend the minimum effort on communicating with stakeholders who have neither interest nor power in this situation. As valuable as they might be to the hospital’s operations, maintenance workers, who fall into this category, should not be at the top of your mind in leading this particular initiative. But you would need to pay a lot of attention to them in a different setting—for example, in a process-improvement project aimed at optimizing the facilities management function.

This kind of analysis, if you are not used to doing it, might seem overly calculating. But your ultimate goal is a practical one—managerial effectiveness. By understanding exactly with whom you need to communicate and how, you can maximize the impact of your ideas. There are two important reasons why broad involvement of many different stakeholders is crucial to your success as a communicator. First, stakeholders can offer their knowledge, expertise, attitudes, and suggestions about your ideas. By organizing this collective intelligence, you sharpen your own thinking. Second, stakeholders will be more committed and knowledgeable through being involved. And the more committed stakeholders are, the more willing they will be to support your ideas.

TOOLS FOR MANAGING ORGANIZATIONAL COMMUNICATION

After identifying stakeholders, assessing their interests, and developing strategies for overcoming potential communication barriers, the next step is to select methods for consulting with them. Table 6.1 describes various tools for engaging stakeholders in an organizational communication process. You should choose methods on the basis of your goals. "Nominal Group Technique," for instance, helps draw out ideas from a small group of stakeholders, while questionnaires are more successful at representing the opinions held by a larger population. The issue of broad representation generally becomes more important as an organizational initiative moves into the implementation phase.

The methods can be divided between those most appropriate for small- and large-group communication—with the methods listed farther down in the table generally being more appropriate for larger, less personal settings. The methods or mix of methods that work best vary according to the situation. But your managerial focus should always be on tailoring communication as much as possible to fit the profile of a particular person, group, or organizational culture.

SOCIAL NETWORKS AND SOCIAL MEDIA

The most recent research on communication has highlighted the importance of social networks—the connections among a group of people and the broader environment in which they live and work. In settings of all kinds, people get things done and spread information through these informal channels (Burt, 2007; Christatkis and Fowler, 2009; Powell, 1998). The extent of your network constitutes your "social capital" and is one of your most important assets as a communicator. An invaluable addition to stakeholder analysis, a social network map is like an X-ray that reveals the inner workings of your organization and its environment.

In a recent study of treatment guidelines for hypertension, a group of researchers compared two primary-care practices (Scott et al., 2005). Figure 6.7 shows the pattern of relationships for each one. The one on the left has much greater “density”—a measure of the number of connections per person. Other measures reveal that the physicians in this practice spend more time working together collaboratively and engaging in two-way communication. As the researchers predicted, this practice was much more successful at implementing treatment guidelines among its physicians.

Two concepts explain the differences between the practices in adhering to the treatment guidelines: connection and contagion. “Connection” refers to the pattern of relationships that a group of people have. Some networks have mainly
### TABLE 6.1

<table>
<thead>
<tr>
<th>Consulting Modes</th>
<th>Time Required</th>
<th>Objectives</th>
<th>Description</th>
<th>Representative</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open-ended interviews</td>
<td>30 minutes–1 hour</td>
<td>To obtain responses to relatively complex issues and alternatives</td>
<td>Interviewer poses questions to respondent</td>
<td>No</td>
<td>Complicated questions may be entertained; may suggest other questions to be explored in more structured formats</td>
<td>Dependent on the interviewing skills of the interviewer, time consuming, expensive</td>
</tr>
<tr>
<td>Structured interviews</td>
<td>15 minutes–1 hour</td>
<td>To obtain responses to relatively complex issues and alternatives</td>
<td>Interviewer poses questions to respondent</td>
<td>Yes, with appropriate sampling</td>
<td>Complicated questions may be entertained. Valuable for generating questions for more standardized formats</td>
<td>Dependent on the interviewing skills of the interviewer, time-consuming, expensive</td>
</tr>
<tr>
<td>Nominal Group Technique</td>
<td>1/2 hour–2 hours</td>
<td>To increase and balance participation among meeting participants</td>
<td>Individual generation of ideas in writing, followed by group discussion and ranking of ideas</td>
<td>No</td>
<td>Easy to learn, easy to use, produces broad participation</td>
<td>No interaction among ideas and issues</td>
</tr>
<tr>
<td>Interview design</td>
<td>1–2 hours</td>
<td>To stimulate interaction among large groups (16–200) and reveal similarities and differences among their ideas</td>
<td>Several rounds of one-on-one interviewing by group members, followed by summaries of interviews</td>
<td>No</td>
<td>Active involvement of group members, rapid generation of ideas</td>
<td>Not appropriate for exploring a particular idea or proposal in depth</td>
</tr>
<tr>
<td>Focus group</td>
<td>2–3 hours</td>
<td>To generate hypotheses about the way members and customers think</td>
<td>Open discussions among 6–12 people, facilitated by a trained moderator</td>
<td>No</td>
<td>Flexibility, open to unexpected responses, good for exploring unfamiliar terrain</td>
<td>Dependent on facilitator’s ability, peer pressure can silence some participants, interpretation can be difficult</td>
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<tr>
<td>One-minute essays</td>
<td>1–3 minutes</td>
<td>To provide a brief opportunity for reflection on a discussion</td>
<td>Brief writing exercise or key takeaways from a discussion</td>
<td>No</td>
<td>Quick, easy to do, offers a chance to digest information</td>
<td>Not appropriate for sorting out complex proposals</td>
</tr>
<tr>
<td>Consulting Modes</td>
<td>Time Required</td>
<td>Objectives</td>
<td>Description</td>
<td>Strengths</td>
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<tr>
<td>Short questionnaire</td>
<td>15–30 minutes</td>
<td>To solicit information about specific topics</td>
<td>Prepared questions with limited range of responses</td>
<td>Respondents have opportunity to reflect on responses, no chance of interviewer influencing</td>
<td>Low response rate, no opportunity for interviewer to clarify questions, small amount of information gathered, takes time to develop effective questions</td>
<td></td>
</tr>
<tr>
<td>Long questionnaire</td>
<td>1/2 hour – 1 hour</td>
<td>To solicit information about specific topics</td>
<td>Prepared questions with limited range of responses</td>
<td>More information gathered with brief questionnaires</td>
<td>Same disadvantages as brief questionnaires, except length further reduces response rate</td>
<td></td>
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<tr>
<td>Mini Delphi</td>
<td>15–30 minutes (for each round)</td>
<td>To produce a consensus ratio-scaled evaluation of alternatives</td>
<td>Respondents prioritize alternatives, then repeat exercise after seeing the average rankings from previous rounds</td>
<td>Gives geographically dispersed respondents the chance to interact with each other, anonymity prevents bias</td>
<td>Assumes the desirability of the average response</td>
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<tr>
<td>Workshop designs</td>
<td>1/2 – 1 day</td>
<td>To provide a structured setting where participants collectively explore issues in depth</td>
<td>Events where small and large groups engage in facilitated discussions and exercises</td>
<td>Derives key alternatives from open-ended interviews, then sets data on current state, desired future state and relative importance</td>
<td>Time-consuming, requires careful design work, difficult to meet participants' heightened expectations</td>
<td></td>
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<tr>
<td>Exploring strategic options</td>
<td>1/2 – 1 day</td>
<td>To develop a strategic agenda</td>
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</table>

**TABLE 6.1 (Continued)**
a hub-and-spoke configuration, where one person resides at the center of several relationships. There may be several hubs and a few connections between the hubs. Another configuration is mainly hierarchical, where a few people sit “atop” others and send information “down” through a network. And then there are networks like the first primary-care practice, characterized by lots of interconnections between people. These patterns influence whether and how information spreads through a network.

"Contagion" explains how the information spreads. Biologically, people have evolved to mimic others’ behavior. In mimicking behavior, they also pick up corresponding emotions. As the authors of Connected note, there is a lot of truth in the saying, “When you smile, the world smiles with you.” In one of the strangest epidemics ever recorded, in 1962, an outbreak of uncontrollable laughter spread in Tanzania from one person to another until it “infected” over 1,000 people. Four schools were forced to close, and villages were paralyzed. Just like this “illness of laughing,” new treatment guidelines spread among professionals who work closely with each other. You are much more likely to “catch” them than someone who spends most of their time working in isolation.

The practical value of a social network map is that it shows how you should manage the flow of information in your organization and its environment. If you know that it has a hub-and-spoke structure, then you should target the “hubs.” You can bring them together for a meeting, using one or more of the consultation methods described earlier. Once the “hubs” have bought into your proposal, you can rely on them to spread it through the surrounding “spokes.” Or, if you work in a more hierarchical environment, you should focus on...
Clinical information and should continue to be funded. The data also suggest a particular set of management practices will maximize the DONs' impact as "hubs": establishing regional advisory councils, offering professional development courses, and disseminating information resources online.

The point about online information-sharing raises an important issue related to social networks: social networking. Web 2.0 technology offers a dizzying array of options for using social media for building social networks: e-mail, blogs, tweets, IMs, wikis, and other electronic communication tools that continue to appear with amazing speed. As a manager and health care provider, which channels should you choose? Research reaching out to those at the "top." They will facilitate the flow of information "down" through the rest of the organization.

A recent study of health care outreach organizations is a good example of using a social network map in this way (Michigan Department of Community Health, 2009). Researchers assessed the effectiveness of several Diabetes Outreach Networks (DONs), organizations dedicated to promoting diabetes prevention, detection, and treatment. Their findings reveal that, as illustrated in Figure 6.8, the most successful DONs had a central, "hub" position in their social networks.

From a policy perspective, one of the most important implications is that the DONs play an invaluable role in spreading clinical information and should continue to be funded. The data also suggest a particular set of management practices will maximize the DONs' impact as "hubs": establishing regional advisory councils, offering professional development courses, and disseminating information resources online.

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The information they need to make the best decisions. Today, this often requires striking the right balance between virtual and face-to-face communication for each patient. The researchers Ben Gerber and Arnold Eiser found that, as decision makers, patients fall into two broad categories: the “knowledge acquirer” and the “informed decision-maker” (Gerber and Eiser, 2001). The knowledge acquirer is the more passive one—more comfortable with the physician as the ultimate authority. But this patient may still want to learn about his or her condition. In this case, you can “prescribe” a Web site that provides background on healthy diets or home care. These patients are more likely to comply with behavioral advice if a health provider has “primed” them before they review online material that supplements other information sources. The informed decision maker wants to participate more fully in making decisions. You can make face-to-face meetings with these patients more productive by directing the information they need to make the best decisions.

Consider, for example, patient communication. Since patients do better when they are knowledgeable and actively involved in their care, health care providers must give them the right balance of psychological and informational needs. When the need for psychological contact is high, you should lean toward “high-touch” encounters. If informational needs are strongest, you should rely more on social media tools.

Figure 6.8 A Social Network Map.
them to sites where they can use credible information to educate themselves.

Patients who are comfortable working online can handle routine informational issues using social media tools. At Patientsite.org, at Boston’s Beth Israel Deaconess Medical Center, patients read and send e-mail, make appointments, see personal test results, and refill prescriptions. They also access information about wellness services, medication management programs, and decision-making tools. In this setting, social media are useful in “broadcasting” information to a whole population of patients.

In managing organizational communication, you should design a system that includes both face-to-face and virtual channels. Stakeholder preferences should guide your choices about which ones to use and with whom. The benefit for you as a manager will be a social network—an “invisible” but powerful organization existing “inside” the formal hierarchy—that amplifies the impact of your programs and initiatives.

**COMMUNICATION NETWORKS**

Another way to view your communication strategy is through the concept of “communication networks” (Longest and Young, 2006). You can create these networks to achieve various objectives. Figure 6.9 illustrates five basic patterns that scholars have identified. Each pattern is appropriate to different managerial situations.

The following examples illustrate the practical uses to which you can put the concept of a communication network:

- **Chain**: Simple hierarchical communication is most like a chain. Messages flow downwards and upwards from one level to another. Basic factual information, like work schedules or requests for vacation days, can be communicated in this way.
- **Y**: In a Y pattern, people report up to a superior, who in turn has a dual reporting relationship to two separate superiors. As a chief operating officer, for instance, you might recommend that a senior nurse in a large clinical department report directly to the department chair and to the chief nursing officer, each of whom has a “stake” in his or her performance at the departmental level. This ensures that both departmental and enterprise-wide “interests” are represented in the reporting relationship.
- **Wheel**: A wheel is suitable when you have to communicate with several people who have no need to communicate directly with each other. When you keep important stakeholders from different parts of an organization “in the loop”—department chairs, administrators, and staff—you are following this pattern.
- **Circle**: Peers, such as division chiefs, often communicate in a “circle” between regularly meetings and events. Anyone can communicate with anyone else, but no one is formally managing or controlling the communication. As a senior administrator, you might encourage this kind of self-managing information flow as a conscious strategy.
• All-Channel: Real-time team meetings are venues where “all-channel” communication takes place. Information flows freely as team members speak directly to each other.

Like social networks, communication networks are conceptual tools for managing the flow of information across large and complex organizations. They help organize your thinking about communication strategies.

ORGANIZATIONAL POLITICS

Even if you are a master of stakeholder management, know how to manage the flow of information through social and communication networks, and are comfortable with social media tools, you cannot avoid organizational politics. There is plenty of evidence showing that politics is a reality in most workplaces. Studies have found that some political activity takes place in nearly all organizations. And in nearly half, it takes place to a “very great” or “fair” extent. If you consider yourself “above” politics, you condemn yourself to being dominated by those who are willing to get into the trenches and fight. As the ancient philosopher Plato said: “Those who are too smart to engage in politics are condemned to being governed by those who are dumber.” As a leader, therefore, you must be prepared to get involved in this often rough-and-tumble activity.

A good example of the skillful combination of communication finesse and political savvy is Richard Shannon, a physician who led an effort at Allegheny General Hospital to reduce the incidence of lethal infections in the ICU (Institute for Healthcare Improvement, 2005). He started small, realizing that there would be too much resistance among many stakeholder groups to making large-scale procedural changes all at once. With seed money for a small pilot project, Shannon implemented a zero-defect problem-solving process inspired by Toyota’s lean production techniques. The results were stunning: catheter-related bloodstream infections (CRBLIs) and ventilator-associated pneumonias (VAPs) were reduced by 87 percent and 83 percent, respectively. Then Shannon focused on getting traction with two key stakeholder groups: the nurses and residents. “We estimate that our efforts probably saved 47 lives,” he said. “Once the staff saw we could have that kind of impact, they were immediately on board.”

Next, Shannon turned his attention to getting support from senior management. He adjusted his communication strategy accordingly. He noted that this group of stakeholders had a distinctive perspective: “Their job is to look at costs, but they don’t get to see the consequences of poor quality care case by case. They see aggregated data, which blunts the financial impact.” Shannon thus highlighted the financial impact of a case involving a single patient who suffered from multiple complications caused by a catheter infection. “The hospital had to absorb more than $41,000 on that one case,” Shannon noted. In addition, he discovered, “30 to 70 percent of the total went for treating the infection or the complications it caused.” In total, the hospital could save millions by controlling infections—specifically, $2.2 million. This figure got the attention of senior management as well as the hospital’s largest insurer, who ponied up a $2.1 million bonus to keep the work going.

Paul Levy, who was featured in Chapter 2, was similarly skilled in responding to the bare-knuckles politicking at Beth Israel Deaconess Medical Center. Soon after he took over as CEO, he laid out his communication ground rules (Grey, 2006). Anybody could criticize his plans, as long as they did so openly and offered constructive alternatives. Following a meeting with department chiefs, Levy received a rude challenge to this principle. One of the chiefs had sat silently through a discussion of operational problems. Afterwards, he sent a harshly critical e-mail to Levy lambasting his plans and copied all of the other chiefs and the chairman of the hospital’s board. Rather than address the chief’s criticisms in private, as earlier administrators might have done, Levy openly confronted the chief in a bluntly worded e-mail. Levy made it clear he was not going to be bullied. The other chiefs, who were tired of endless sniping and wanted action, became even stronger allies of Levy. But Levy knew when to respond with softer gestures, too. When one group of nurses rebelled over work rules, leading to scores of resignations, Levy established a group of task forces to look into the issue. Once the nurses had an opportunity to work collaboratively on solving their own problems, turnover dropped from 15 percent to 4 percent.

The stories of Richard Shannon and Paul Levy show that effective communication requires that you think carefully about the political interests of key stakeholder groups. For Shannon, the key group was the senior administrators, who had the power to expand the small-scale initiative into an enterprise-wide initiative. Shannon tailored his communication to speak directly to their financial perspective. Levy made an attention-getting point about his leadership in standing up publicly to a disrespectful department chief. But Levy also knew when to back off and let an important stakeholder group—the nurses—find its own solution to a dispute over work rules. Organizational communication is like basketball—skill, timing, judgment, and even luck are all part of the game.
COMMUNICATION AS A LEADERSHIP ART

Most health care organizations are complex, high-pressure work settings that include multiple disciplines and professional belief systems. To communicate successfully in this environment, you must learn to adapt to the “local culture” and speak many different “languages.”

The need to adapt to stakeholders raises an important leadership issue: authenticity. Will you lose credibility and self-respect if you become a shape-shifter, changing yourself for each new audience? As actress Judy Garland once said, “Always be a first-rate version of yourself instead of a second-rate version of somebody else.”

The English philosopher and politician Francis Bacon, who rose to become one of the most powerful men in England in the late 1500s under Queen Elizabeth I, tried to manage virtually every impression he made with people at the royal court. He filled his journals with observations and advice to himself on how he should appear to others in pivotal encounters and drew lessons from each success and failure to take to his next meeting. For example, he once wrote that he needed to “suppress at once my speaking with panting and labor of breath and voice” in conversing with one of the queen’s closest advisors. Bacon’s goal was to create a separate and distinct “public self” as an instrument of persuasion.

Behavioral experts Rob Goffe and Gareth Jones have wrestled with the apparent paradox that impression management presents (Goffe and Jones, 2005). Your personal credibility, which has its roots in perceived consistency and trustworthiness, provides the foundation for influence. Yet effective communicators are, as these authors say, “like chameleons, capable of adapting to the demands of the situations they face.”

Is it really possible to be a “credible chameleon”? Yes, in the following sense: You play many roles in your life—spouse, parent, professional, employee, boss, sports fan, customer, community leader, student, and teacher. In each of these roles, you naturally display different aspects of yourself. Your child’s third-grade teacher sees a different side of you than does your boss, and your brother or sister probably sees a different person than does your child. Nevertheless, it is always just “you.”

Thus, the authenticity paradox diminishes somewhat when you see that you cannot help being a somewhat “different person” depending on who you are communicating with. And your awareness of these various roles gives you a range of “authentic selves” to draw from in each encounter. The art of communicating as a leader involves knowing which “self” to be: sympathetic listener, master of ceremonies, social networker, or harsh taskmaster.

DEBATE TIME: Is Strategic Communication Really Just Manipulation?

There are many examples in this chapter of leaders who adapted their messages and communication styles to fit a particular situation. Take the case of Dr. Richard Shannon. While he used the language of finance when he was communicating the benefits of lean production techniques to senior administrators at Allegheny General Hospital, he emphasized clinical outcomes when he sought the buy-in of medical staff. In another show of adaptability, Paul Levy at Beth Israel Deaconess Medical Center used strong-arm tactics in dealing with a disruptive surgeon, but he used a much gentler approach with nurses who were upset over work rules. When does “adaptability” become “inauthenticity”?

The very concept of a “stakeholder analysis” might raise a similar question. In using a “Power-Interest Matrix” to categorize stakeholders, you are assigning different levels of importance to people and groups. In executing a communication strategy based on such an analysis, you will pay more attention to some groups than to others. Is this fair?

Finally, management experts Rob Goffe and Gareth Jones propose that leaders should work to become “credible chameleons,” adapting themselves to each situation so that they increase the likelihood of being understood. This advice may make some people uneasy. Shakespeare said, “To thine own self be true.” Shouldn’t you follow this principle rather than trying to be all things to all people?

From the perspective of an organizational leader, weigh the pros and cons of “being yourself” versus being a politically savvy “credible chameleon.” In what kinds of situations might it be advisable to show flexibility, and when, if ever, should you simply speak your mind without carefully crafting a communication strategy?
SUMMARY AND MANAGERIAL GUIDELINES

1. In any managerial situation, pay attention not only to the substance of your intended message but also to the ways your message can be distorted.

2. Map the stakeholders of an organization, creating communication strategies appropriate to each stakeholder group.

3. In designing a communication strategy for an entire organization, use different channels for each purpose and audience: town hall meetings, one-on-one briefings, written memos, e-mails, etc.

4. Use multiple communication styles in disseminating organizational policies and strategy: data-oriented, emotional, and visionary.

5. Maximize “organizational learning” by engaging in robust, two-way communication with staff and external stakeholders.

6. Always work to enhance your credibility as a leader, building your reputation for trustworthiness, competence, and expertise.

7. Analyze and actively manage social networks to influence the flow of information within and around your organization.

8. Be willing, when necessary, to engage in “organizational politics” even if you have implemented a highly structured communication strategy.

9. Work hard to be a “credible chameleon” by getting in touch with your multiple “authentic selves” that enable you to make contact with many different kinds of people.

DISCUSSION QUESTIONS

1. Describe Aristotle’s model of communication.

2. How did recent communication theorists build on Aristotle’s model?

3. What are the Five Barriers to communication, and how do you remove them?

4. Identify three different methods for consulting with stakeholders in a complex communication process. Explain the objective as well as the strengths and weaknesses of each method.

5. How is the National Cancer Institute’s “Patient Centered Communication Model” different from the simple sender-receiver model?

6. How does the concept of “contagion” help explain how information spreads in social networks?

7. Why do leaders need to take account of organizational politics?

CASE: The Case of Jesica Santillon

It is extraordinarily difficult to manage communications in health care settings. Few cases offer a better illustration of that difficulty than Jesica Santillon’s. She was a 17-year old girl who died in 2003 after undergoing a heart and lung transplant in which, at one of the nation’s top medical centers, she received organs with the wrong blood type.

Her tragic story shows how social, technical, and organizational complexity combines to create daunting communication barriers for health providers and administrators. Consider the complicating factors in this situation, and the related leadership questions they raise:

• The Family. Jesica’s parents smuggled her into the country from Mexico, hoping to find a cure for a heart and lung disorder that doctors in her home country could not treat. The family settled in North Carolina, settling down in a trailer. They soon came to the attention of a local builder, who started a charity that eventually raised enough money for her to receive
a transplant at Duke Medical Center. The procedure went terribly wrong, leading to severe and irreversible brain damage. When the doctors informed Jesica’s mother they planned to stop treatment, she announced at a press conference, through a translator, “They are taking her off of the medicine little by little in order to kill her. They want to rid themselves of this problem.”

Questions

1. **Leadership question:** What social and cultural barriers may have made it difficult for the doctors to communicate with Jesica’s family? What might have the doctors done to increase the chances that Jesica’s family understood the true nature of the problems in this terrible circumstance?

   - **The Procedure.** A heart and lung transplant is obviously a challenging procedure. Though Dr. James Jaggers, the chief of pediatric surgery at Duke University, was a highly skilled and well-regarded physician, he was just one among many professionals involved in a multistep process that began with the location of suitable organs somewhere in North America and continued through transferring the patient to the intensive care unit (ICU). The many handoffs required in this process meant there was a risk of important information being lost or garbled at key transition points, as in the “whisper down the lane” game. This is in fact what happened. Jesica’s Santillon’s blood type was O, while the organs’ was A. Carolina Donor Services located the organs and, they claimed, informed Dr. Jaggers of the organs’ blood type. Dr. Jaggers does not remember the conversation about it. Another physician was sent to pick up the organs in Boston. He was informed three times of the blood type, but since he did not know Jesica’s blood type, he was not aware there was a mismatch.

2. **Leadership question:** How would you organize the complex set of steps required in this transplant process to ensure that misunderstandings do not occur in handoffs between professionals?

   - **The Stakeholders.** Following the string of errors leading to the mistaken transplant, the Duke Medical Center had to manage a whole set of stakeholders: the Santillon family, the family’s lawyers, the community, the press, and the health provider community. Each stakeholder group had its own interests, influenced by their cultural, social, and professional backgrounds.

3. **Leadership question:** If you were the Duke Medical Center CEO, what general communication strategy would you put in place to manage the stakeholders in this case? In particular, how would your messages to each group differ from the others?

Adapted from a CBS News story. Original text retrieved from http://www.saynotocaps.org/trailoftears/jesica_santillan.htm

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