

Communication and Team Working in Health Care

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Teamwork, Communication and Effectiveness in Health Care

The activity of a group of people working co-operatively to achieve shared goals is basic to our species. The current enthusiasm for teamworking in health care reflects a deeper, perhaps unconscious, recognition that this way of working offers the promise of greater progress than can be achieved through individual endeavour.

But what is teamwork? Mohrman, Cohen and Mohrman (1995) define a team as:

“a group of individuals who work together to produce products or deliver services for which they are mutually accountable. Team members share goals and are mutually held accountable for meeting them, they are interdependent in their accomplishment, and they affect the results through their interactions with one another. Because the team is held collectively accountable, the work of integrating with one another is included among the responsibilities of each member”.

The concept of teamwork as the most effective way of delivering products and services has gained increasing ascendancy within diverse organisational settings (Guzzo & Shea, 1992; West, 1996). So much so, that it is now a dominant philosophy within manufacturing, service, private and public sectors with the UK, as well as internationally (Goodman, 1986; Sundstrom, De Meuse & Futrell, 1990). This approach to the delivery of services and products is by no means simply a managerial fad, since there is substantial empirical evidence that the introduction of teamwork and group goals in diverse organisational settings, and involving diverse task types, can lead to increased effectiveness in the delivery of both quantity and quality of goods or services (Guzzo & Shea, 1992; Weldon & Weingart, 1993).

The idea that teams are important to modern organisations was established about 70 years ago. However, only in the past 15 years has that idea been seized and widely acted on by large numbers of organisations in the public and private sectors (Guzzo, 1996). But how effective are teams within organisations generally?

Macy and Izumi (1993) conducted an analysis of 131 organisational change studies in order to determine their effectiveness. Those interventions with the greatest effects on organisational performance and ‘the bottom-line’ were team-related interventions. These also reduced turnover and absenteeism more than did other interventions, showing that team-oriented practices can have broad positive effects in organisations. Other research by Kalleberg and Moody (1994) who studied over 700 work establishments, found that those in which teamwork was developed were more effective in their performance than those in which teams were not used. Finally, Applebaum and Batt (1994) offer similar evidence. They reviewed the results of a dozen surveys of organisational practices, as well as 185 case studies of innovative management practices. They too found compelling evidence that teams contribute to improved organisational effectiveness, particularly increasing efficiency and quality.

The importance of teamworking in health care has been emphasised in numerous reports and policy documents on the National Health Service (NHS). One (NHSME, 1993) particularly emphasised the importance of teamworking in health and social care for people were to be of the highest quality and efficiency:

“The best and most cost-effective outcomes for patients and clients are achieved when professionals work together, learn together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service.”

Some limited research has suggested the positive effects of multidisciplinary teamworking in health care. Primary care teamworking has been reported to improve health delivery and staff motivation (Wood, Farrow, & Elliott, 1994) and to have led to better detection, treatment, follow-up and outcome in hypertension (Adorian, Silverberg, Tomer & Wamosher, 1990). Jones (1992) reports on one US study in a primary health care setting showing that families receiving team care had fewer hospitalisations, fewer operations, more physician visits for health supervision and less physician visits for illness than control families.

There is also evidence that teamworking can lead to positive impacts for the health care professionals themselves. In a study in Spain, Peiró et al. (1992) showed relationships between work team climate, role clarity, job satisfaction and leader behaviours. Effectiveness of teamwork was also related to job satisfaction and mental health of team members. West and Wallace (1991), in a study of five innovative and three traditional UK primary health care teams, found that team innovativeness was positively related to team collaboration, commitment and tolerance of diversity. In recent research we have found that those working in teams in NHS trusts are at much lower risk of burnout and stress than those not working in teams.

However, there are also very real problems of teamworking and communication in health care. West and Slater (1996) reported a great deal of potential benefit from teamworking in areas such as communication, constructive debate, support for new ideas, role understanding across professional disciplines, growth and development of health professionals, organisational efficiency and setting objectives and appropriate skill use. However, this potential was not being realised, with less than one in four health care teams building effective communication and teamworking practices (see also West & Poulton, 1997).

In a similar vein, the Audit Commission report in 1992 drew attention to a major gap between the rhetoric and reality:

“Separate lines of control, different payment systems leading to suspicion over motives, diverse objectives, professional barriers and perceived inequalities in status, all play a part in limiting the potential of multi-professional, multi-agency teamwork ... for those working under such circumstances efficient teamwork remains elusive” (Audit Commission, 1992).

This statement highlights the problems faced by health care teams at both the team and organisational level. Difficulties with communication (e.g., over team objectives in leadership style) as well as organisational barriers (e.g., different payment systems, lines of control) lead to ineffective communication and teamwork within the NHS.

✧ One of the best known studies was conducted by Bond, Cartilidge, Gregson, Philips, Bolam, & Gill, (1985), who examined interprofessional communication and collaboration in primary health care via a survey of health visitors, district nurses and GPs. Three hundred and nine pairs of professionals (comprising 161 GPs and health visitors, and 148 GPs and district nurses) were surveyed where they had patients in common. Interviews, questionnaires

and records were used to explore the extent of collaboration. The research results suggested that GPs had a moderately good understanding of the district nursing role, but a very poor understanding of the health visitor's role. Levels of communication and collaboration between GPs and community nursing staff were low.

✧ McClure (1984) conducted a survey of 48 health visitors and 45 district nurses attached to general practices over a period of ten years, one-third of whom were working from premises with attached groups. Health visitors were not enthusiastic about progress in teamwork and community nurses generally reported that communication with practice staff was usually only about specific immediate patient issues rather than team objectives, strategies, processes and performance review.

✧ Cant and Killoran (1993) reached similar conclusions, based on their research study with 928 practice nurses, 682 health visitors and 679 district nurses. They argued that joint professional training, training in teamwork, and the instigation of regular team meetings to promote good communication were necessary ways forward.

✧ West and Field (1995) and Field and West (1995) report interviews with 96 members of primary health care teams and a number of factors which impact upon teamworking and communication in health care, including structured time for decision-making, personality and status, group decision-making, team cohesiveness and team-building. They refer to the failure of health care teams to set aside time for regular meetings to define objectives, clarify roles, apportion tasks, encourage participation and handle change - eventually good communication. Other reasons for poor teamwork and communication include differences in status, power, educational background, assertiveness of members of the team, and the assumption that the doctors will be the leaders (see also West & Pillinger, 1995; West & Slater, 1996).

Recent research suggests the broader context within which teams work has an overriding influence on their effective communication and performance. The organisational context of the team is one such factor.

Organisational Context

The organisation within which a health care team functions can influence team effectiveness in a variety of powerful ways. Researchers, such as Hackman (1990) and Tannenbaum, Beard and Salas (1992) have pointed to the many contextual factors which influence team effectiveness. These include:

- How people are rewarded in the team and organisation
- Ready access to task-related information and clear feedback on performance
- Training for the job and for teamwork
- The necessary technical assistance to support the team in its work
- An organisational climate which is supportive both of people and of teamworking
- The extent of competition and political intrigue within the organisation
- Relations between teams in the organisation - competitive versus mutually supportive

Many of these factors are directly relevant to health care teams and their surrounding environment. Firstly, rewards - it has long been known in the social sciences that rewards are

important for improving performance. Psychologists describe how individuals increase certain behaviours when they are rewarded for performing them. For example, people will place more effort and work towards quality, if quality is rewarded. Therefore, performance will be more effective if there is an explicitly contingent reward. However, team performance is most effective when rewards are administered to the team as a whole and not to individuals, and when they provide incentives for collaboration and communication rather than individualised work (Hackman, 1990). This will reinforce team members to work together as a team rather than working as disparate individuals, and will also allow all team members to receive a reward for their contribution to the team's performance. Yet, the NHS system sometimes directly contradicts this ideal system. Bonus systems to GPs for example, and their independent contractor status both directly undermine teamwork in primary health care. When bonus payments are paid to one individual or group of individuals within the team, the concept of 'team effort' is eroded. In addition, as the whole team contributes to the final outcome, the team members who are not rewarded will inevitably become frustrated and angry.

Ready access to data and feedback should be available to the team. Health care team members need information about local health needs and services, and national policies and guidelines, if their scarce resources are to be targeted appropriately. Feedback on team performance is also essential for both learning and effectiveness. Monitoring the effectiveness of strategies used by the team and locality health gain can provide such information. This can then be discussed by the whole team. In a similar way, training and technical assistance must also be readily available from the organisation. This is needed to supplement team members' own technical and medical skills and knowledge. Training for teamworking and communication is especially important in a complex context such as health care, be it in a trust or in a primary health care team (Poulton & West, 1993; Poulton & West, 1994a, 1994b; Poulton & West, 1997).

The climate of the organisation - how it is perceived and experienced by those who work within it - will also influence the effectiveness of teams (Allen, 1996). Where the climate is one characterised by high control, low autonomy for employees, lack of concern for employee welfare and limited commitment to training, it is unlikely teamworking will thrive (Markiewicz & West, 1997). The extra commitment and effort demanded in team-based organisations requires organisational commitment to the skill development, well-being and support of employees (Mohrman, Cohen & Mohrman, 1995). Competition and intrigue further undermine teambased working in health care, since teamwork depends on shared objectives, participative safety, constructive controversy, excellent communication and support (West, 1990; West & Anderson, 1996).

In a comprehensive study of team-based organisations involving both questionnaire and case study methods, Mohrman et al. (1995) have also demonstrated that inter-team competition is a major threat for team-based working. Teams which compete may develop greater commitment to the team's success than the organisation's success. Thus the multi-disciplinary health care team may focus on increasing the resources for their team at the expense other teams in the trust. Teams competing against, rather than supporting, each other may withhold vital information or fail to offer valuable support in the process of trying to achieve team goals, without reference to wider goals of the trust. Thus, health care teams may fail to pass on information about former patients to other teams, focusing their efforts on their own team's immediate demands.

The size of the team is also important, since bigger teams experience much greater strains on effective communication. Most other sectors have teams which start to break down after they reach 12 or 13 members. But primary and secondary health care teams (for example) can be 20, 30 or 40 members in size. These 'teams' would be more correctly termed 'organisations'. In and of itself, this would not be a problem, if those who run such organisations are adequately trained to manage large operations. They require knowledge of the management of culture, power, conflict, spans of control, strategies, innovation and above all, people. Yet primary health care team members are rarely given such training (West, 1994).

Finally, the management structure of health care teams can lead to complete breakdowns in communication, confusion, differing objectives, and separate agendas. In primary health care for example, midwives can be managed by hospital trusts, district nurses by district nursing managers, health visitors by health visiting managers in the community trust, practice nurses by GPs, and practice managers supposedly managing receptionists and administrators but having very little power in relation to GPs. GPs are not clearly being managed by anyone. This is likely to lead to each team member working, communicating about, and aiming towards different, and sometimes quite divergent, directions.

Conclusions

The challenges of effective communication and teamwork in health care are great, but the potential benefits for improved health of local populations and team member well-being are also very great (Carter & West, in press). Many factors inhibit effective teamwork, especially in the context of teamwork in health care - separate managerial lines of control, status of doctors, gender issues, lack of clear objectives for health care teams, lack of training for teamworking and people management, and the size of many 'teams'. That is quite apart from the complexity of the task. Those working in such teams must be proactive in developing effective teamworking by communicating about and clarifying their team vision and objectives, encouraging full participation of team members, committing to constructive controversy and excellence, and supporting innovation in process and practice. But it is critical that these teams are not passive entities within trusts and health authorities, localities or the NHS more generally. Effective teams reflect upon and communicate about their workings and their work environment - they revolutionise their organisations by clamouring persistently and coherently for the organisational conditions and supports which enable effective communication and teamworking in the provision of health care for local communities. This radical approach requires continued good communication, strength of purpose and persistence, but, in the service of improving health in local communities, the effort may well seem worthwhile to committed health professionals.

Key Points

Carrying out work in teams can have benefits both for achieving work goals and ensuring the well-being of health professionals.

There are organizational barriers to effective teamworking which must be removed and replaced by supports to ensure the effectiveness of teamworking.

Within teams, clear objectives, high levels of communication and participation, commitment to excellence, and support for innovation lead to effective performance.

Overall, teams in demanding, complex environments, such as health care, must develop reflexivity - a capacity to reflect upon and adapt their objectives, strategies, communication and decision-making processes, as well as the organizational context.

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