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NEW PERSPECTIVES

Building effective clinical teams in healthcare

Zoheir Ezziane
Healthcare Management Group, Imperial College Business School, London, UK and The Wharton Entrepreneurship and Family Business Research Centre, University of Pennsylvania, Abu Dhabi, United Arab Emirates

Mahiben Maruthappu
Harvard University, Cambridge, Massachusetts, USA, and

Lynsey Gawn, Emily A. Thompson, Thanos Athanasiou and Oliver J. Warren
Department of Surgery and Cancer, Imperial College Healthcare NHS Trust, St Mary's Hospital, London, UK

Abstract

Purpose – This article aims to review teamwork and the creation of effective teams within healthcare.

Design/methodology/approach – By combining research material found in management, psychology and health services research the article explores the drivers increasing the importance of teamwork, reviews the current knowledge base on how to build a team and focuses on some of the barriers to effective team performance.

Findings – The simultaneous inflation of healthcare costs and necessity to improve quality of care has generated a demand for novel solutions in policy, strategy, commissioning and provider organisations. A critical, but commonly undervalued means by which quality can be improved is through structured, formalised incentivisation and development of teams, and the ability of individuals to work collectively and in collaboration. Several factors appear to contribute to the development of successful teams, including effective communication, comprehensive decision making, safety awareness and the ability to resolve conflict. Not only is strong leadership important if teams are to function effectively but the concept and importance of followership is also vital.

Research limitations/implications – Building effective clinical teams is difficult. The research in this area is currently limited, as is the authors' understanding of the different requirements faced by those working in different areas of the health and social care environment.

Originality/value – This article provides a starting place for those interested in leading and developing teams of clinicians.

Keywords Healthcare management, Team working, Clinical leadership, Teambuilding, Safety awareness, Decision making, Conflict resolution, Health services

Paper type General review

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Introduction

Teamwork, the ability of a group of individuals to work together has often been associated with improved outcomes and reduced costs. Despite this, several studies have identified a lack of evidence and guidance on how teamwork should be employed and nurtured in the health care setting. This article explores the drivers increasing the importance being placed on teamworking, reviews the current knowledge base on how to build a team and focuses on some of the barriers to effective team performance, namely poor leadership and followership.

Drivers for increased teamwork and team building

Healthcare, both process and outcomes, has improved significantly in recent years. Arguably our ability to do more for patients has however oft resulted in, or coincided with, rising cost and complexity. Increased patient autonomy and expectations, emphasis on quality and safety, and a willingness to look at other industries for guidance and transferable learning has led to increased attention being placed on teamwork and the dynamics of team interactions (Porter-O'Grady, 2010). These drivers have occurred within healthcare in a global sense, but more specifically within the NHS the development of strategies to improve teamwork as one way through which to achieve improved access, improved patient outcomes and improved patient satisfaction (e.g. Donaldson, 2003; Waring and Currie, 2009; Cooper *et al.*, 2011). Teamwork in health care has been defined as:

> A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making (Xyrichis and Ream, 2008).

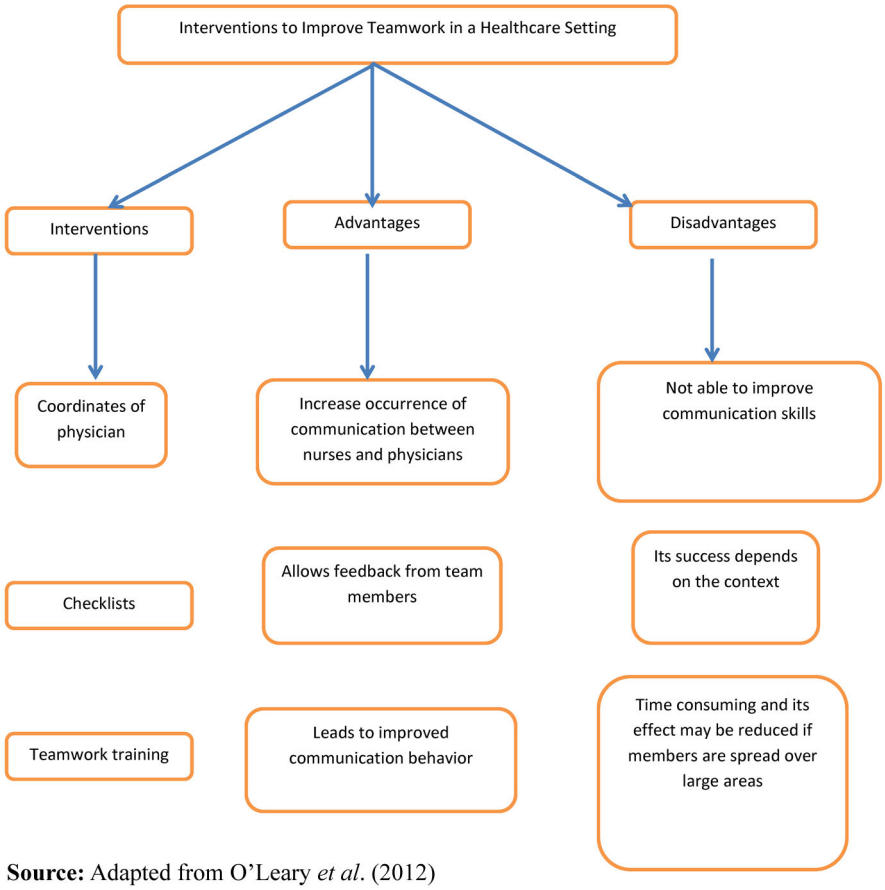
How can such collaboration and co-production be generated in a structured manner? West *et al.* (1998) proposed that three criteria are required:

(1) the definition of a team's function and identity;

(2) the development of shared objectives; and

(3) the generation of independent roles for team members.

The employment of such strategies has been shown to be of benefit. West *et al.* (2006) found that, across 52 hospitals in England, after controlling for previous mortality rate and confounding factors including doctor-to-patient ratio, human resource management significantly decreased patient mortality. Conversely, the development of "pseudo-teams"; those without common health goals, open communication and information sharing, has been correlated with reduced organizational performance. O'Leary *et al.* (2012) find that "hospitals with high teamwork ratings experience higher patient satisfaction, higher nurse retention, and lower hospital costs" (see Figure 1). A study of the Veterans Health Administration by Meterko *et al.* (2004) reported that teamwork culture was heavily correlated with overall patient satisfaction (see also Sorbero *et al.*, 2008). Evidently in healthcare as a whole, teamwork, and our ability to both lead and follow within teams, is not really optional but the key to being able to deliver care that is patient centred and of high value.



Source: Adapted from O'Leary *et al*. (2012)

Figure 1.
Common interventions to improve teamworking in healthcare institutions

Building a team – areas of consideration for healthcare leaders

A review of the relevant literature finds several factors that contribute to the development of successful teams, including effective communication, comprehensive decision-making, safety awareness and conflict resolution:

Communication

Several studies have shown that the majority of communication is non-verbal (70 percent), with 23 percent of communication being conveyed via intonation, and just 7 percent through content (Mehrabian, 1971). In the Joint Commission report on Accreditation of Healthcare Organizations (The Joint Commission, 2006), communication was said to represent one of the most important elements of teamwork and failings within it were estimated to be the root cause for almost 70 percent of sentinel events. Unfortunately, communication through content or written means, such as e-mail, has exponentially increased, removing several important aspects of interaction, in turn fragmenting and isolating health care workers, rather than encouraging team-building. Clinical leaders must therefore harness appropriate

methods of communication to better direct their teams, organising regular meetings, aiming to create an environment that welcomes independent expression of a team member's views.

Decision-making

Decisions lie at the centre of patient-care, be it over the date of discharge or decision to resuscitate a patient. In the group and team settings, several studies have shown a tendency for members to conform to group decisions for fear of vulnerability and animosity should they differ in opinion, a concept referred to as "groupthink" (Janis, 1982). Gair and Hartley (2001) demonstrated that doctors in particular were more likely than other healthcare professionals to accept decisions contrary to their initial suggestions. Drawing from these points, it is crucial that clinical leaders nurture independent thought and encourage feedback on decisions from all team members, removing work-enforced hierarchies and driving towards multidisciplinary and multilevel team decisions.

Safety awareness

In the context of high-risk, fast-paced environments such as A&E, and the operating theatre, safety awareness is paramount. Crew-resource-management (CRM) is a method that has shown significant promise in addressing this element. CRM was initially developed by NASA to minimise human-error and communication related aviation accidents. It is now being adapted and employed in healthcare to improve situational awareness, enhance communication and reduce hierarchy-related barriers. CRM applications may be used in many health care settings including emergency rooms, labor and delivery, and operating rooms. For example, adapting training methods from military helicopter aviation to emergency medicine (Small *et al.*, 1999); applying active simulation training methods in cardiac arrest response situations (Gaba *et al.*, 2001); and using robotics for minimally invasive cardiac surgery (Pisano *et al.*, 2001).

Conflict resolution

Conflict can be of benefit in precluding "groupthink" and encouraging the discussion of alternative solutions. However, in many circumstances, following disagreement, confrontation and escalation occurs and can create disharmony in teams. It is therefore important that a clinical leader is able to foster negotiation and compromise in such situations, more specifically aiming towards group-trust, shared commitments and mutual respect of opposing views.

Making a team effective

Once a team has been built, it is important to next consider how that team can be led to perform well. Salas *et al.* (2008) presented a practically relevant model that advocates team training for the purpose of improving effectiveness. This model includes the following five major components: team leadership, mutual performance monitoring, backup behavior, adaptability, and team orientation. Several studies have also shown that effective teamwork correlates with reduced hospitalization times, decreased costs, service provision improvement, increased patient satisfaction and reduced mortality. To create this transformation from a close-knit team to a high-performing team, several

elements are required, including close supervision, appropriate assignment of responsibility, and removal of barriers to team implementation. Many authors have demonstrated that high performing teams tend to collect data, lots of it, and frequently present or publish it in the public domain (e.g. Donaldson, 2009; Gawande, 2008). They encourage peer review and critical appraisal of their work and are more likely to be transparent than secretive, being confident in their own abilities and processes.

Identifying appropriate responsibilities for team members

The identification of roles for team members is key to cohesive engagement towards common goals. Indeed, it has been shown that failure of role-assignment to team members is one of the most significant causes of stress in the work place (West *et al.*, 1998; Porter-O'Grady, 2010) and in our experience is an all too frequent event in modern healthcare. As demonstrated by Figure 2, several methods can be implemented to impose clarity on team-dynamics and responsibilities.

Barriers to team working: rethinking leadership and followership

While the elements presented previously remain key points for considering how to build effective teams, it is of no surprise to readers that forming and maintaining teams needs a substantial effort (Mortimer *et al.*, 2004). This is particularly the case in healthcare as the existence of dynamic environments and hierarchy within institutions represent a significant barrier to achieving effective teamwork between healthcare professionals (O'Leary *et al.*, 2010; Makary *et al.*, 2006; Thomas *et al.*, 2003). In order to make teamwork happen we suggest will require two crucial determinants: leadership and followership.

Leadership

Teams need leaders. Collections of people rarely spontaneously form into an effective group united behind a common goal or vision and work in a methodical, effective and conflict-free manner towards achieving said aim. However, barriers exist which inhibit the emergence of such leaders and thus reduce the likelihood of effective teams being built and subsequently supported to perform. Of particular note, several barriers have prevented clinicians from undertaking leadership roles that would allow them to nurture effective teams. The most significant barrier in our view is the apprehension within the medical profession towards leadership and management; the managerial and administrative influences encouraged in recent years through increased performance management, a target culture and increased financial focus on all processes have created tensions between managers and clinicians. This has led to increased distrust of those clinicians who attempt to adopt leadership roles or "cross to the dark side" by taking on management positions. However, without leaders, teams

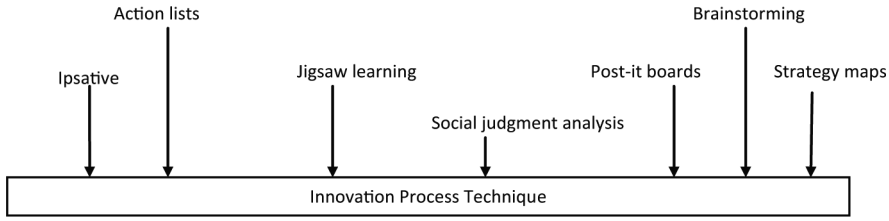


Figure 2.
Example of innovation process methods

cannot be led or built, and thus there has been an equal and opposite drive to improve clinical leadership and increase the attractiveness of it as a "sub-speciality"

Another contra-leadership culture derives from a belief among some clinicians, particularly "clinician-scientists" or those in academia that leadership, team-work, management and communication skills are "unscientific", as spurious qualities not worthy of much consideration (Maynard, 2011) or lying contrary to the role of patient advocate. We would argue that such qualities are essential for effective, modern multidisciplinary approaches, and that unless teams are led and function well, all health care professionals involved in a patient's care may not feel able to contribute to decisions regarding effective patient care. Furthermore, in no other serious high-risk industry is the importance of leadership and team working as disciplines questioned so significantly; indeed to do so would likely appear counter-corporate.

Followership

Just as leadership is vital, so is followership. It is critically important for team members to have a positive attitude towards each other and avoid toxic anti-team behaviors in order to achieve successful team performance. Followership style includes two major categories: "participation" which could be either passive or active, and "thinking" which ranges from dependent/uncritical to independent/critical (Miller, 2007). Hence, there are many types of followers ranging from the relatively ineffective, whereby s/he is passive, with dependent/uncritical thinking, to a highly effective follower who practices both independent/critical thinking and active participation (Kelley, 1992). Miller (2007) gave practical examples of effective followers in the perinatal/neonatal area, such as the nurse who communicates very clearly and objectively when she is asked to provide a plan of care, or a doctor who listens to suggestions on adopting different procedures from nursing colleagues. The nurse states that "[. . .] at the hospital where I practice, any nurse or nurse-midwife can call for the C-section team to be assembled. Even though the decision to do the C-section will ultimately be made by the physician ('leader'), the nursing or midwifery staff ('followers') can, and are encouraged to, call for the team in an emergency, thus avoiding dangerous delays in time-sensitive situations." This example shows that effective followership promotes a flattened hierarchy and patient safety. It also suggests an element of mutual trust between "leader" and "follower" and fluidity in the role of decision maker.

Kelley (1988) reported the following four qualities of effective followers:

(1) they manage themselves well;

(2) they are committed to the organization and to a purpose, principle, or person outside of themselves;

(3) they build their competence and focus their efforts for maximum impact; and

(4) they are courageous, honest, and credible.

We think it is interesting to take these qualities in turn, and think how they might apply to the healthcare professional. First, many work often with little supervision and with a great deal of responsibility in terms of their access to the vulnerable and to sensitive information. As such, their ability to be pro-active and to self-manage and self-regulate we would postulate to be relatively high. Second, the patient should represent the common purpose or principle to which followers should be committed.

Having said that, this has been threatened by commitment to other organizations, professional identity and the self more broadly, and we would postulate that organizational commitment and "corporate buy-in" has frequently been missing in healthcare, particularly in the NHS'. Third, most professionals within the health service whether clinical or non-clinical need to continually improve their knowledge and skills and apply what they learn within their working environment. Increasingly these are qualities we believe are frequently seen within healthcare contexts. Finally, healthcare professionals are, by selection and by training, honest and ethical (Hertig, 2010). We would thereby conclude that a lot of the ingredients required for good followership practice are likely exist within healthcare settings but that there needs to be further emphasis and development to ensure good team functioning.

Limitations and implications for future research

While both the academic and mainstream retail literature on leadership and its development is vast, the same cannot be said for that on teams and teamworking. The published research on how to assess, build, encourage and develop effective teams is limited. However, this may need to rapidly change. As some groups have suggested, the days of the heroic individual are likely gone, and the need for all clinicians to be able to effectively move between and work within functioning teams now paramount (The Kings Fund, 2011).

The concept itself can be hard to define and therefore to measure. Context is key; the requirements of teams involved in delivering good district nursing or social care across a small area are likely to differ from those of a trauma team in a major trauma centre (Arthur *et al.*, 2003) (Guo and Company, 2007). What is more, the language we use around these sorts of concepts varies by organization, profession and setting (El Ansari, 2011).

The current situation does however create plenty of opportunities for further research looking at how team working might be improved by particular types of training, and assessing the effectiveness and influence of team skills training on optimising multidisciplinary interdependence in the health care environment (Fitzgerald and Davison, 2008). Many effective ingredients of teamwork are still unexplored and any link between improved teamwork and improved value of care has yet to be determined.

Conclusion

A growing body of evidence demonstrates that teamwork significantly impacts on the quality of care provided. This article has outlined the principles required to build a team, namely effective communication, comprehensive decision-making, safety awareness and conflict resolution. The transformation from a close-knit team to a high-performing, effective team has also been discussed, involving the clear assignment of roles and regular face-to-face meetings between team members. A deeper element in health care namely the potentially contra-leadership culture must be challenged if truly effective teams are to be nurtured within the National Health Service and beyond. Shifting culture and introducing the aforementioned principles into training will likely help us rise to the challenge of providing better, safer and more efficient care in the face of economic threat.

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Corresponding author
Oliver J. Warren can be contacted at: *o.warren@imperial.ac.uk*

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