

THE UNIVERSITY OF MANITOBA

SCHOOL OF SOCIAL WORK

AN EXPLORATORY STUDY OF AN INTERDISCIPLINARY

TEAM PRACTICE BASED IN A CHILD

DEVELOPMENT CLINIC

by

SANDRA H. HARRISON

Submitted in partial fulfillment of the  
requirements for the degree of Master of Social Work,

University of Manitoba,

September, 1980

AN EXPLORATORY STUDY OF AN INTERDISCIPLINARY  
TEAM PRACTICE BASED IN A CHILD  
DEVELOPMENT CLINIC

BY

SANDRA HUGHINA HARRISON

A thesis submitted to the Faculty of Graduate Studies of  
the University of Manitoba in partial fulfillment of the requirements  
of the degree of

MASTER OF SOCIAL WORK

© 1980

Permission has been granted to the LIBRARY OF THE UNIVER-  
SITY OF MANITOBA to lend or sell copies of this thesis, to  
the NATIONAL LIBRARY OF CANADA to microfilm this  
thesis and to lend or sell copies of the film, and UNIVERSITY  
MICROFILMS to publish an abstract of this thesis.

The author reserves other publication rights, and neither the  
thesis nor extensive extracts from it may be printed or other-  
wise reproduced without the author's written permission.

## ACKNOWLEDGEMENTS

I would like to express my appreciation to those people whose assistance, co-operation and support made this study possible.

Special thanks go to the members and clients of the Child Development Clinic of the Health Sciences Centre who contributed their time and knowledge to provide the information for this study.

I also wish to thank my advisor and committee members, Ranjan Roy, Addie Penner and Bruce Tefft, for their interest and assistance throughout this study.

Special appreciation is also extended to Terry Robinson for his continuous support and encouragement throughout this project.

## ABSTRACT

Team practice is increasing in popularity and occurrence as it is perceived to be an effective and efficient method of providing the services of a few professionals to many clients however, individual practices in specific settings have rarely been studied in a consistent, systematic way.

In response to this need, this thesis is an exploratory study of an interdisciplinary team practice based in a child development clinic. Eight work processes - leadership, team roles, communication processes, decision-making and problem solving processes, the team purpose, conflict resolution, interactional processes of the team and its host organization, and the team's functional use of group process - are examined. Questionnaire and interview techniques were utilized to collect the relevant data.

The responses obtained from these instruments were coded and analyzed to provide a description of this team at work, its work style, structure, and its weaknesses and strengths. The methodology does not allow for the broad generalization of the findings across settings but some general interpretations can be made: 1) the C.D.C. is not a team according to Brill's (1976) definition rather it is a collection of interdisciplinary professionals who work together towards a common goal; 2) its members are generally satisfied with its work style although there are some discrepancies between the member's perceptions of, and the actual work processes used by the unit; 3) inconsistencies between ideal team practices as defined in the literature and this unit's practice suggest that existing definitions of team practices are deficit as they include

only structural components and not attitudinal/emotional components,  
4) modifications in the C.D.C.'s work process would increase its  
resemblance to an ideal (lateral) team practice, and 4) professional  
conflicts and the founding philosophy and working style of the original  
C.D.C. unit has determined its present work style.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS.....	i
ABSTRACT.....	ii
LIST OF TABLES.....	vii
LIST OF FIGURES.....	xii
LIST OF APPENDICES.....	xiii
CHAPTER I INTRODUCTION.....	1
I. The Problem.....	1
II. Rationale for the Study.....	1
III. Definition of Terms.....	2
IV. Outline of the Remaining Chapters.....	4
CHAPTER II REVIEW OF THE LITERATURE.....	6
I. Team Practice - Its History, Its Advantages and Disadvantages	
A. History.....	6
B. Advantages and Disadvantages.....	8
II. The Medical Model and Team Structure.....	9
Alternative Team Structures.....	13
III. Analyzing Team Functioning.....	17
Work Process I. The Definition and Practice of Leadership in the Team.....	20
Work Process II. Role Definitions.....	26
Work Process III. Communication Processes in The Team.....	32
Work Process IV. Decision-Making and Problem Solving Processes in the team..	35
Work Process V. Definition of the Team's Purpose.....	39
Work Process VI. Conflict Resolution Processes in the Team.....	42
Work Process VII. The Interactional Process of The Team and Its Environment (ie. Host Organization).....	45
Work Process VIII. The Team's Functional Use of Group Process.....	49
IV. Conclusion.....	51
V. Summary.....	52

	Page
CHAPTER III METHODOLOGY.....	53
I. The Subjects.....	53
II. The Instruments.....	53
A. The Staff Interview Schedule.....	53
B. Team Effectiveness Diagnostic Instrument.....	54
C. Supplementary Sheets.....	54
D. Client Evaluation Questionnaire.....	55
III. The Procedure.....	55
IV. Summary.....	56
CHAPTER IV RESEARCH FINDINGS.....	57
I. Staff Demographics and Team Interview Schedule and Team Effectiveness Diagnostic Instrument Findings....	57
A. Demographic Characteristics of the Staff.....	57
B. Staff Interview Schedule	
1. Team Members	
(a) Leadership.....	59
(b) Team Member's Roles.....	65
2. Communication	
(a) Record Keeping.....	71
(b) Staff Meetings, Case Conferences, Rounds, etc.....	72
3. Problem Solving and Decision-Making...	76
4. Task Assignment.....	83
5. Team Purpose.....	87
6. Conflict.....	89
7. Environment.....	94
C. Team Effectiveness Diagnostic Instrument.....	97
1. Goal Agreement on the Team.....	97
2. Role Ambiguity on the Team.....	98
3. Role Conflict on the Team.....	100
4. Decision-Making on the Team.....	101
5. Commitment to Team Decisions.....	103
6. Conflict Management on the Team.....	104
7. Intermember Respect and Recognition...	106
8. Cohesiveness on the Team.....	106
II. Client Sample Demographics and Client Evaluation Questionnaire.....	109

	Page
III. Other Findings.....	124
CHAPTER V DISCUSSION OF THE FINDINGS.....	125
I. Interpretation of the Findings.....	125
A. Team Leadership.....	128
B. Team Member's Roles.....	129
C. Communication on the Team.....	131
D. Problem Solving and Decision-Making on the Team.....	134
E. The Team's Purpose.....	137
F. Conflict on the Team.....	137
G. The Team and Its Environment (Host Organization).....	139
H. Client Perceptions of the Service Provided by the C.D.C. Team.....	141
I. Inter-Professional Relationships on the Team.	142
II. Suggestions and Recommendations ....	145
III. Implications of the Findings ....	146
IV. Limitations of the Study.....	152
V. Conclusion.....	154
APPENDICES	
"A".....	155
"B".....	160
"C".....	169
"D".....	173
"E".....	174
"F".....	178
"G".....	179
"H".....	180
BIBLIOGRAPHY.....	182



## LIST OF TABLES

Number	Table	Page
1	Comparison of Medical Team and Lateral Team Model	14
2	New Cases opened at C.D.C. - March 1980	55
3	Team Membership	58
4	Designated Team Leader	59
5	Occurrence of Shared Leadership	60
6	Professionals Sharing Leadership	60
7	Team Members Excluded from Acts of Leadership	61
8	Formal Team Leader's Leadership Style	61
9	Existence of Informal Team Leader	62
10	Members Acting as Informal Leaders	62
11	Team Member's Desire to Lead the Team	63
12	Leader Emphasis	64
13	Primary Roles of Team Members	66
14	Role Negotiability	67
15	Role Negotiation	67
16	Occurrence of Role Overlap	68
17	Overlapping Roles	68
18	Consequences of Role Overlap	69
19	Suggestions for Increased Service or Involvements by Team Members	70
20	Occurrence of and Contributions to Common Team Records	71
21	Private Files Kept and Shared	72
22	Occurrence of Staff Meetings	72
23	Meetings Held, Their Participants, Their Function and the Frequency of Occurrence	73

Number	Table	Page
24	Team Member's Desire for More Team Meetings	74
25	Purpose of Proposed Meetings	74
26	Team Communication Patterns	75
27	Effectiveness of the Team's Communication Pattern	76
28	Primary Team Decision-Makers	77
29	Degree of Member Influence into Decision-Making	78
30	Areas of Member Influence/No Influence on the Team	78
31	Member's Satisfaction with Degree of Influence they are allowed	79
32	The Team's Decision-Making Pattern	80
33	Degree to which the Team Leader Encourages Inter member Consultation	80
34	Consultation Patterns on the Team	81
35	Helpfulness of Intermember Consultation	82
36	Team Member's Perceptions of Patients' Awareness of C.D.C.'s Team Approach	83
37	Team Member's Perception of the Effects of Team Practice on Clients' Satisfaction with Service	83
38	Types of Cases Seen by Team Members	85
39	Cases Each Member Feels He Should See	86
40	Extent to which Member's Treatment Plans/Suggestions are followed	86
41	Team Member's Purposes	87
42	Team's Purpose - Formal or Assumed	88
43	Team's Focus re: Patient Care	88
44	Occurrence of Conflict on the Team	89

Number	Table	Page
45	Conflict Issues on the Team	90
46	Conflict Management on the Team	91
47	The Team's Climate	92
48	Team Member's Satisfaction with Team's Climate	93
49	Team Member's Suggestions for Improved Conflict Management	93
50	Team Member's Direct Supervisors	94
51	Team Member's Responsibilities Outside of C.D.C.	95
52	Team Member's Awareness of C.D.C.'s Association with its Host Organization	95
53	Team Member's Overall Perceptions of Agreement on Team Goals	97
54	Specific Team Member's Perceptions of Agreement on Team Goals	98
55	Team Member's Overall Perceptions of Role Ambiguity	99
56	Specific Team Member's Perceptions of Role Ambiguity	99
57	Team Member's Overall Perceptions of Role Conflict	100
58	Specific Team Member's Perceptions of Role Conflict	101
59	Team Member's Overall Perceptions of Degree of Member Participation in Decision-Making	102
60	Specific Team Member's Perceptions of Degree of Member Participation in Decision-Making	102
61	Team Member's Overall Perceptions of Degree of Member Commitment to Team Decisions	103

Number	Table	Page
62	Specific Team Member's Perceptions of Degree of Member Commitment to Team Decisions	104
63	Team Member's Overall Perceptions of Patterns of Conflict Resolution	105
64	Specific Team Member's Perceptions of Patterns of Conflict Resolution	105
65	Team Member's Overall Perceptions of the Degree of Intermember Respect and Recognition	106
66	Specific Team Member's Perceptions of the Degree of Intermember Respect and Recognition	107
67	Team Member's Overall Perceptions of Team Cohesiveness	107
68	Specific Team Member's Perceptions of Team Cohesiveness	108
69	Age of Children in Client Sample	110
70	Presenting Problems of Client Sample	111
71	Referral Source of Client Sample	112
72	Team Members Involved in Casework and Focus of the Casework	113
73	Family Status and Residence of Client Sample	115
74	Concessions made by C.D.C. for Clients with Special Needs	116
75	Clients' Perceptions of Helpfulness of C.D.C.	117
76	Clients' Perceptions of Kinds of Help Given by C.D.C.	117
77	Client Contacts by C.D.C. Staff as Perceived by Client Sample	118
78	Team Member's Contacts with Client Sample	119

Number	Table	Page
79	Team Member's Contacts with the Referred Person	120
80	Clients' Perceptions of Degree to which C.D.C. Keeps them Informed	121
81	Clients' Current Involvement with C.D.C.	121
82	Clients' Reasons for Termination with C.D.C.	122
83	Clients' Satisfaction with C.D.C.	122
84	Clients' Satisfaction with C.D.C. as recorded by Presenting Problem	123
85	Clients' Satisfaction with C.D.C. as recorded by Family Status and Residence	123
86	Comparison of Medical, Lateral and C.D.C. Team Models	126
87	Member's Suggestions for Improving the C.D.C. Team	145
88	Presenting Problems of Cases Excluded from Client Sample (seen by one Team Member)	180
89	Team Member Involvement and Focus of Casework in Cases Seen by One Team Member	181

LIST OF FIGURES

Number		Page
1	Consultation Patterns on the Team	81

LIST OF APPENDICES

	Page
A. Koop's Analytic Framework	155
B. Staff Interview Schedule	160
C. Team Effectiveness Diagnostic Instrument	169
D. Intake Sheet and Supplementary Sheet	173
E. Client Evaluation Questionnaire	174
F. Cover Letter	178
G. Follow-up Letter	179
H. Cases Excluded from Client Sample	180

CHAPTER I  
INTRODUCTION

I. The Problem

Team practice is increasing in popularity and occurrence as it is perceived to be an effective and efficient method of providing the services of a few professionals to many clients (Kane, 1975 a and b; Brill, 1976; Horwitz, 1970; Beckhard, 1972). While more is being written about teams, their structures and work processes, individual teams in specific settings have rarely been studied in a consistent, systematic way.

II. Rationale for the Study

A review of the literature dealing with team practices (see Chapter II) reveals that concepts of group process, management and structure have been borrowed from industrial and bureaucratic organizational theory and group theory, compiled and then presented as team "theory". In reality, this "theory" is merely a speculative prescription for team practices. For example, lateral team practices based on democratic principles is advanced in the reviewed literature as being superior to other models of team practice, specifically, the medical model (see Chapter II). In reality, this claim has not been systematically tested. In fact, scientific explorations of actual teams in practice are rarely found.

Professional journals do carry some reports about specific teams but these reports are unscientific, impressionistic and are written from one team member's perspective. (Examples: Social Science and Medicine (3) 1969 p. 95-100; Canadian Journal of Public Health (62) March - April 1971



p. 101-104). These reports contain only partial information about the team's structure, its procedures for assigning tasks and for formulating and carrying out casework plans. Little or no information is provided about the team's leadership, conflict management processes, decision-making and problem-solving processes, communication system(s), the team's morale, team member's roles and how these are decided upon; little is reported on the clients' perceptions of the team's effectiveness.

These gaps in the reviewed literature and subsequently in existing knowledge about team functioning makes it imperative that individual team practices be systematically and scientifically explored in all of the areas mentioned above in order to advance knowledge about team practice beyond the prescriptive stage.

With this need in mind, this thesis shall undertake an exploratory study of one team's practice. The purpose of this study, in general terms, is to define a team in practice. Specifically, the following areas will be explored: the team structure, leadership on the team, team roles, the communication processes in the team, decision-making and problem-solving processes in the team, the team's purpose, conflict management in the team, the interactional processes of the team and its host organization, and the team's functional use of group process. The clients' perceptions of the team's effectiveness will also be examined.

The subject of this study is the Child Development Clinic's team (hereafter referred to as C.D.C.), Health Sciences Centre, University of Manitoba, Winnipeg, Manitoba.

### III. Definition of Terms

It is appropriate at this time to define the terms which will appear most frequently throughout this thesis. It must be understood

that many definitions for each term have been considered throughout the reviewed literature but only those definitions felt to be most appropriate and clearly stated will be presented here.

Brill (1976) has presented the definitions for both "team" and "teamwork" that hold the most meaning for this writer and which shall be incorporated here:

"A team is a group of people each of whom possesses particular expertise; each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate, and consolidate knowledge, from which plans are made, actions determined and future decisions influenced." (Brill, 1976, p. 22).

Further, teamwork<sup>1</sup> is that work which is done by the team (Brill 1976, p. xvi).

The helping professions are noted for two types of team models which are still in the evolutionary process of development - intra-disciplinary and interdisciplinary. The hallmark of each is who its members are, their academic and personal backgrounds, their areas of responsibility, and the expected rewards (Brill, 1976). This thesis will only deal with the interdisciplinary team but definitions for both team models will be provided to promote understanding.

Brill (1976) defines the intradisciplinary team as one whose members are from one discipline but who represent different aspects

---

<sup>1</sup>Teamwork differs from job-sharing in that the latter is "a voluntary work arrangement in which two people hold responsibility for what was formerly one full-time position." (Olmsted, 1977). Job-sharers have common areas of expertise and their focus in terms of providing service are perforce the same.

within that discipline. They may or may not have varying levels of academic accomplishment but do have varying roles within the team (p.93).

The interdisciplinary team differs in that its members are from different disciplines. Their skills are both unique to the profession and to the individual professional. The members may and often do represent different academic levels of achievement (Brill, 1976, p.93).

Richard Scott (1974) in his work, uses a similar definition but goes on to further label the intradisciplinary team as a "specialist group" and the interdisciplinary team as a "task group". The difference is based on the members in the group and the reason for its formation.

The literature reviewed tells of other work which has been done in an attempt to more narrowly define different types of teams but for the purposes of this thesis, Brill's (1976) definitions are adequate. This thesis is concerned with the interdisciplinary medical model of team practice which may be described as a task group. It generally consists of four main professional representatives - physician(s), social worker(s), psychologist(s), and nurse(s) - and is based in a community clinic.

#### IV. Outline of the Remaining Chapters

Chapter I has defined the problem to be confronted in this thesis and has described the overall purpose and importance of the study. Finally the definition of those terms used most frequently throughout the thesis have been presented.

Chapter II shall present a review of the research literature in three parts. The first section shall present an historical overview of the team practice. A summary of the literature

dealing with the medical model and the lateral model of team practice will follow. The third section will present a summary of Horwitz (1970) and Koops (1976) framework for analyzing team functioning as well as an examination of the eight work processes considered necessary for a comprehensive study of a team practice.

Chapter III includes a description of the methodology and research design used in this study. The findings from the study are presented in Chapter IV while a discussion of the findings is presented in Chapter V.

## CHAPTER II

### REVIEW OF THE LITERATURE

The literature review of this research thesis is divided into three sections. The first section consists of an historical overview of team practice, as well as a summary of its advantages and disadvantages. The second section consists of a review of the medical model of team practice in which the structural and ideological concepts of this model are presented. The third section consists of a summary of Horwitz (1970) and Koop's (1976) framework for analyzing team functioning. Eight team work processes are identified and discussed.

#### I. Team Practice - Its History, Its Advantages and Its Disadvantages

The next section in this chapter will present, albeit briefly, a review of the literature dealing with the work processes of an interdisciplinary team practice. First however, a condensed historical review and rationale for team practice will be presented.

##### A. History

Teamwork is not a new concept for its existence has been cited in the writings of Hippocrates and also in the Bible. However, it has more recently been brought into vogue by the helping professions by the increasing demand by the public for improved and increased service delivery (Brill, 1976; Brieland, et al, 1973; Brock, 1969). This new demand is felt to have emerged following World War II when there was both an increase in knowledge and a general attitudinal change in how the needs of people were being viewed. The social scientist's response to these changes was to become more specialized by dealing with only one major area of human need at a time. The resulting frustration due to the low rate at which clients' needs were still being met, in combination with

the realization that parts of man cannot be dealt with in isolation, led to a review of this approach. The holistic view wherein man is looked at as a summation of his parts in relation to his environment, led the specialists into the adoption of the team model as a way to increase service delivery and to meet the total needs of their clients (Brill, 1976; Horowitz, 1970; Brill, 1976; Briggs and Luenberger, 1973). The social workers along with many other professionals had realized that no one person can be all things to any other person (Brill, 1976).

Medical personnel had been working together in groups of two or more, long before this. The prototypical example of this is the nurse-physician unit. (One must be careful not to apply the term "team" in its truest sense to any working unit.) Earlier writings in the Bible testify to physician-assistant relationships but not until more recently have paramedical professionals been considered as possible members of a medical "team". Despite the fact that Mary Stewart, an almoner in England, was included in the hospital scenario (Brock, 1969) as early as 1895, little progress was made in incorporating social work as a viable professional member of most treatment teams. However, as the holistic approach to meeting human needs has been increasingly adopted by "helping" professions, the social worker has gained a recognized position on many medical teams, e.g., mental health teams, rehabilitation teams, child care teams, etc. (Kane, 1975; Butryn, 1967). Drew (1953) put the necessity for this working relationship very succinctly:

". . . total patient care is really nothing more than good medical and social work practice. It is medicine and social work in which no phase of the patient's problem is neglected in an effort to return him to his previous place in society."  
(p. 25)

## B. Advantages and Disadvantages

The rationale for teamwork seems reasonable enough. It is, of course, not the only nor the best treatment modality for every situation.

The advantages and disadvantages of the team work approach to service delivery have been discussed in the literature. A general consensus seems to have been reached with regard to the major pros and cons of its use. These are identified here.

The advantages seem to be that team practice:

1) allows for personal growth of the individual members through participatory learning,

2) provides a medium for specialization while providing an integrated service to the client,

3) promotes a focus on the total problems presented rather than on specifics and also allows for the opportunity to talk about how the parts fit together,

4) encourages the team focus to be on the goals that provide a direction for mutual efforts, thus producing more meaningful work,

5) possesses "emergent qualities" which lead to self-actualization and self-renewal and thereby promote personal and group growth,

6) has the potential of increasing the range and quality of services offered to clients through multi-professional expertise and in so doing, deals with the economic problem of supply and demand of client needs vs. availability of workers,

7) provides a medium for examination and evaluation of ideas in light of differing frames of reference.

(Brill, 1976; Brieland et al, 1973; Kane, 1975; Wise, 1974.)

Some major disadvantages seem to be that team practice:

- 1) May be a slow moving and cumbersome process in its attempts to be a democratic organization,
- 2) lessens the number of client-worker contacts as the group works in the client's interests and not always with the client,
- 3) may have difficulties in communication which may limit the team's effectiveness,
- 4) may lead to fragmentation of services rather than an integration of services,
- 5) team meetings may be more time consuming than consultations and referrals outside the team framework,
- 6) tensions between disciplines and the lack of clear definitions of boundaries of knowledge and expertise may make teamwork difficult,
- 7) some workers in all the human services are not only ill-prepared for teamwork, but are also not committed to it.

(Brill, 1976; Kane, 1975; Brieland, et al, 1973; Wise, 1974)

As team practice is a relatively new method of service delivery, there is no conclusive evidence that the advantages outweigh the disadvantages or vice versa. The literature reviewed, however, seems to feel that the potentials for team practice are great.

## II. The Medical Model and Team Structure

The previous section has presented a brief historical review and rationale for team practice. This mode of service delivery will now be examined in more detail. This section will describe a classical example of a traditional team practice, the medical model, and will also describe some newer still evolving models of team practice.



Traditionally health teams operate in close alliance with established medical facilities, whether within a hospital or clinic, or within their adjacent communities. When people work together over a long period of time, an operational system emerges (Watt, 1973). Watt (1973) notes that the type and duration of this system depends upon multiple factors, such as physical and social proximity of its members, the common perception of a shared goal or the compatibility of diverse goals and the ascribed and achieved status of each of its members. In addition, Watt notes that the ideal and actual roles of the members determine the structure of the communication and behavioral patterns.

Established hospitals and clinics and their departments or sub-units (teams) most frequently operate in the tradition of the medical model, both in ideological stance and structural organization (Perrow, 1973; Binkerhoff & Kunz, 1972; Brock, 1969; Brown, 1973). While the organizational literature reviewed was clear in this point, it was not clear as to a precise definition of the term "medical model". This term is much used but with a variety of implicit rather than explicit meanings. Zax & Cohen (1976) have attempted to clarify the ideological concept of the medical model. Their work shall be adopted in the ideological definition of the medical model concept in this thesis while Susan Watt's (1973) structural concept of the medical model shall be incorporated into our structural definition.

Zax & Cohen (1976) state that "medical model" is a term which offers a conceptual guide to both the cause of illness and to the best

methods for handling illness. For them, the medical model describes a set of assumptions and practices that resemble the typical practice of somatic medicine.

Zax & Cohen (1976) outline the central features of the medical model as: 1) illness is viewed structurally, that is, the professional tries to understand the cause and tries to find a remedy for it in order to return the patient to his normal level of functioning; 2) illness is felt to be caused by biological, chemical or physical irritants in the narrowest view of the medical model, but psychological causes are considered in a broader view; 3) the focus of treatment is to overcome the physical or psychological elements presumed to be causing the disorder; 4) the patient assumes a passive role in his treatment while the professional is the active, all-knowing authority, and; 5) the patient approaches the professional and seeks his help but only after the disorder is well underway (p. 63).

This traditional model of patient care has been criticized by such authors as Mechanic (1969) and Zax & Cohen (1976). The major criticisms are aimed at what the model does not do rather than what it does do. It is recognized that in some cases where illnesses due to purely physical causes, the medical model may be the most effective approach to patient care. However, in this model, there is no allowance for problems which may arise out of continuous, adverse influences on the patient over a long time period, rather, the onset of disorder is thought to be acute. Nor is there any allowance for problems that result from social or environmental factors. In fact, in the very narrowest definition of the medical model (the disease or illness model) no allowance is made even for psychological factors. Rather, all illness

is thought to be due to physical causes. The medical model is further criticized for its lack of consideration for preventative medicine; all treatment is of a secondary or tertiary nature. Further, the model is felt to be primarily based on middle class values, making few allowances for class, cultural, ethnic and value differences between patients. The treatment, therefore, may be inappropriate and ineffective for some patients. A last criticism of this model is that it makes no allowances for the evaluation of the appropriateness or effectiveness of the model with regards to patient care, rather, it is assumed to be effective and appropriate across circumstances, patients, therapists and presenting problems.

Zax & Cohen (1976) note that the medical model is not a static concept, rather it is dynamic, undergoing constant yet subtle changes. The latest trends in the model have been towards diagnosing and treating disorders as early as possible. Health professionals are also moving towards more community outreach rather than waiting for the patients to approach them for help once the disorder is underway. These changes are helping to bridge the gap between the preventative model and the medical model of patient care.

As noted, the term "medical model" is used to describe an ideological stance as well as an organizational structure. According to Watt (1973) the team may be viewed as a specialized or task group and as such, develops its own organizational structure just as does its host organization. Such structure may be on a continuum from totally vertical to totally lateral communication and power hierarchies.

Vertically structured organizations are referred to as bureaucracies or as examples of the medical model of organization, and are

characterized by the principle of hierarchial ordering of offices and authority. Perrow (1972) notes that in such a hierarchy, "every person has one person above him to whom he primarily reports and from whom he primarily receives direction. The organization is structured in the form of a pyramid, with the top controlling everything. Power is centralized." (p.32).

Watt (1973) lends support to this concept and notes that the vertical team (See Table I), (or as Horowitz (1970) labels it, the leader centered team, p. 23-24) "invests its members with a graduated, delimited and explicit set of roles with authority, power and responsibility attached to each and understood and subscribed to by each team member. There is always a final authority which in the vertical prototype belongs to the team leader. This team leader usually holds the most socially recognizable expertise both within and without the team (eg. in a vertical medical team, the physician immediately becomes a team leader with the medical specialist superceding the general practitioner or resident).

Vertical team communication systems tend to be unidimensional in descending and occasionally ascending patterns. Power is a function of team position disseminating from the top down. Decision-making is, ultimately, a function of the team leader." (p. 138)

#### Alternate Team Structures

Perrow (1972) notes, as does Watt (1973) that professional organizations or teams are not necessarily structured in the rigid medical model. Perrow states that, according to theory, professional "colleagues are at more or less the same level" (p. 32-3 ) but upon

TABLE I

## COMPARISON OF MEDICAL TEAM MODEL AND LATERAL TEAM MODEL

CONDITION	MEDICAL TEAM MODEL	LATERAL TEAM MODEL
Structure	vertical	horizontal
Leadership	physician	shared by many
Roles	-explicit and fixed; determined by professional membership	-flexible with much overlapping across professions
Communication	-centralized; vertical and formal	-centralized with facility for feedback
Decision-Making and Problem Solving	-vertical with minimal discussion -authority rules	-shared with input from all -consensus rules
Purpose	general with focus on diagnosing and curing patient's physical problems	-explicit; developed and shared by all -focus on providing comprehensive patient care to help patient achieve highest level of functioning
Conflict	detrimental and ignored	valuable and resolved
Relationship with Host	dependent on host; implements all policies and procedures as directed; all members responsible to own departments outside of team	interdependent; has freedom in application of policy and procedure; all members responsible to the team
Use of Group Process	emphasis on task completion -physician given respect and recognition but other members considered his assistants	-equal emphasis on task completion keeping members happy and keeping patient's happy; respect and recognition shared by all

examination of this theory, he adds that "nor should one assume that other professional bodies . . . enjoy the advantages of lack of hierarchy . . . Indeed, any group with a division of labor, professional or not, will be hierarchally structured" (p. 35).

In spite of Perrow's skepticism, a more ideal team structure is advocated for by students of team practice (Brill, 1976; Kane, 1975; Horwitz, 1970; Watt, 1973; Brieland et al, 1973). They suggest that the ideal team structure would be the lateral team (see Table 1) (or, as Horwitz (1970, p. 24-25) labels it, the fraternally centered team) model. In this concept, Watt (1973) notes " communication is on a horizontal plane and power is shared equally by each member involved in the decision-making process. Each participant, while retaining a clear picture of his ideal role, assumes that role flexibility and adaptability is a high priority characteristic of team membership. Power and authority, related to goal attainment, belong to the lateral team as a whole and the process of decision-making is viewed as being of equal importance to the decision made" (p. 138).

Watt (1973) notes that the major difference between the lateral and the vertical team model is that in the former, significantly more complex systems of internal control and less external restrictions exist than in the latter.

Not all team practices precisely fit either of these conceptual models. In her work, Watt (1973) notes that there are cases where a team model fits neither a rigid vertical team concept nor a rigid lateral team concept. She refers to one such psychiatric team as a modified lateral team as it holds more characteristics of the lateral team model rather than the vertical team model in common. Conceivably then, the reverse may also be true.

Section II has presented a description of the traditional medical model of team practice as well the more recently favorite lateral team model. This section has been kept purposely non-critical in order to present various authors perceptions of the two models. However, this purpose having been served, it is important to note the weaknesses in these perceptions.

While the lateral model of team practice appears functional, efficient and effective in theory, its advocates note that such practices are rarely found in practice. The reasons for this may be that:

1) such practices exist but the limited exploratory research to date has not discovered them or, 2) a functional lateral team practice does not exist in practice. At this point in the research history of team practice, it is not possible to rule out either hypothesis. It would appear however, that the concept of the lateral team model as presented previously in this section is extreme and idealistic. At most, it seems likely that resemblances to this model rather than precise duplicates of it, would be the most that a researcher could hope to find in practice.

In either case, it is clear that in order to determine which of the above speculations about the existence of functional lateral team practices is most correct, further research must be undertaken. This brief critique suggests that future researchers might be prudent to study and emphasize what elements and work styles are functional and effective in team practices rather than searching for ideal models.

### III. Analyzing Team Functioning

This section details the work processes considered in the study of the C.D.C. team practice.

Horwitz (1970) and Koop (1976) contend that team functioning can be assessed on the basis of analyzing the work processes of a team (Koop, 1976, p. 19). In order to do this, Horwitz indicates that the answers to the following questions are crucial:

"Who decides what is to be done when? Who decided which worker will perform the task and what techniques to employ? Who helps whom to do what? . . . who decides whether a job has been completed satisfactorily?" (Horwitz, 1970, p. 63).

Koop (1976) took Horwitz's basic concept for analyzing team functioning and organized his eight identified work processes (to follow) into a convenient summary against which to compare observations of a team in action. (See Appendix A) He applied this summary in a Master's of Social Work practicum placement at a multiservice, multidisciplinary social service unit in which he was a participant observer. He found that his organization of Horwitz's concepts was a practical tool for assessing that team's functioning.

Horwitz's (1970) and Koop's (1976) analytic model utilizes the concept of co-ordinative work style and integrative work style. These concepts were coined by John Horwitz (1970b) but were further clarified by Koop. According to Koop "The coordinative work style is characterized by the guarding of autonomy of each worker within some defined practice area. In the coordinative work style, task performance by team members in most cases is successive, or in parallel, and consultations are usually formally arranged. In the coordinative work style suggestions may be welcome, but criticism is out of order. The work style is chiefly



characterized by independent services and decision-making in a confederated milieu" (p. 20).

Horwitz further distinguishes the integrative work style from the coordinative. Koop notes that "the integrative work style is characterized by an attempt to blur the borders of all practice areas. In the integrative work style, task performance by team members is conjoint, and consultations are frequent and informal. In the integrative work style, collegial initiative is practiced in offering uninvited suggestions and comments to a worker. In this work style the work schedule of all becomes the work schedule of each team member. The integrative work style possesses the authority to deploy staff and is characterized by interchangeability of skills. The prime characteristics of the integrative work style is that the planning of the service process is an interdependent process" (p. 20-21).

In reality, ideal work patterns such as the purely coordinative or purely integrative work style rarely exist. Rather, each team develops its own work style which may lie anyway on a continuum from coordinative to integrative, and as Koop (1976) notes, that team's work process may be analyzed in terms of the degree to which they approximate either ideal work style, and can then be plotted on the work continuum.

The literature on team functioning (Kane, 1975; Brill, 1976; Horwitz, 1970a & 1970b; Brieland, Briggs & Luenberg, 1973; Wise, 1974; Rubin & Beckhard, 1972) deals with a variety of variables which they feel are relevant to understanding team functioning. The most common and frequently mentioned processes have been identified by Koop (1976) in his report and are very similar to the processes which this writer has identified in successive studies.

These eight work processes were used in the formulation of the team interview schedule used in this research project. However, before the design and research instruments are explicated, it is necessary to clarify each of the eight processes. Some of Koop's eight work processes have been reorganized and renamed in an effort to promote clarity and understanding. The work processes which will be examined in this section are: 1) the definition and practice of leadership in the team; 2) team role definitions; 3) communication processes in the team; 4) decision-making and problem solving processes in the team; 5) definition of the team purpose; 6) conflict resolution processes in the team and its environment (host organization); 7) the interactional processes of the team and; 8) the team's functional use of group process. As Kane (1975) notes in her work, many of the categories overlap and the divisions are somewhat arbitrary but an attempt has been made to deal with each issue as clearly as possible.

## WORK PROCESS I. The Definition and Practice of Leadership in the Team

Much of the literature pertaining to team leadership has borrowed its ideas from organizational and group theory, therefore this section shall also lean heavily on these areas of expertise to define and examine the leadership process.

Bass (1960), an organizational theorist, cites a literature review completed prior to 1949 which identifies 130 definitions of leadership ranging from leadership as a role, to leadership as a functional process. More recently, Horwitz (1970), a student of team practices, wrote that leadership involves more than status or title. He states that a team leader is not merely possessed of certain traits or characteristics but rather, is the person who can most effectively influence the activities of others. Similarly, another team "expert", Kane (1975) defines leadership as "any conscious act of influence over the behavior of another" (p. 44). As these two authors deal more exclusively with team practices it is their definitions which will be adopted in this thesis.

The key element in these definitions is that of influence. It is implied that one person has influence over another or as Haiman (1951) notes, some must be the followers of the leaders. How is this influence effected?

Bass (1960) suggests that one person influences another through a process of either coercion, persuasion or permission. He states that a powerful person can successfully coerce others to follow him because the power from his position, or his power as a person, makes others expect that he will reward them for compliance or punish them for rejection (p. 221). A persuasive leader, on the other hand notes Bass, is a

person with strong personal power who uses diplomatic suggestion to influence others to follow him and adopt his ideas. Bass sees the permissive leader as one who holds power over others by allowing them the freedom to perform certain activities, that is, he allows his followers to make decisions and select goals within the limits imposed by him. The solutions which they make and which the leader allows, are those which conform to the leader's previously decided upon actions or are new, but equally acceptable solutions. Bass (1960) argues that coercive and permissive leadership are similar and vary only in the degree to which inhibition is imposed (p. 236).

Another key concept in leadership is that of power. Brill (1976) defines it as "the ability to act in relation to others" (p. 96). It can be exercised by an individual team member or by the whole team. The most common sources of power have been identified by Brill (1976) as: the ability to punish or coerce, the ability to reward, the ability to know, which comes from knowledge, skill and expertness, the ability to exercise legitimate authority that is inherent in a position, the ability to exercise influence through allocation of resources both things and people and/or the ability to exercise referent power, which derives from expectations that accompany a certain role to which other people defer (p. 97).

Brill (1976), Kane (1975), Horwitz (1970) and Wise (1974) note that power on a team does not only lie with the leader, rather the power structure on a team exists at two levels, the formal and the informal. The formal structure consists of those team members who are designated by their positions, status and roles as possessing power. The informal power structure consists of those who possess natural abilities to lead. The team should be cognizant of power and where the power lies on the

team as it will affect all team interactions. Power can be used to enhance team effectiveness or it can be used to manipulate the team members to the purposes of a few. These authors note that ideally, power should be used in ways that are consistent with democratic principles.

Organizational theorists have traditionally cited three classic philosophies of leadership - autocratic, laissez-faire and democratic (Beal, 1962). These philosophies have been more recently examined in their applicability to, and effect upon team practices.

According to Beal (1962) and most other organizational theorists, autocratic leadership is often seen in organizations with an hierarchical structure and is characterized by the team being ruled by a power clique of one or a small group of individuals with higher status than their subordinates. The leader advances an idea and it is accepted with little room for discussion or feedback. In these situations, the leader is generally appointed on the basis of prestige or power seizure.

Laissez-faire leadership differs from the autocratic tradition, states Beal (1962), in that it is characterized by a general lack of organization. The leader tends to be passive, while the team members have a great deal of influence on one another and also share in formulating work procedures, decisions and policies.

Beal (1962) and Haiman (1951) describe democratic leadership as that which is characterized by the encouragement of group decisions with each member contributing on a basis of his skills and interest levels. The leader merely guides and coordinates the group process. In this tradition all members are considered as equals and formal hierarchal lines do not exist.

One other leadership style which is not considered to be one of the classics but with which most bureaucrats have experience is that of the benevolent autocrat (McMurray, 1958). This style is thought to span the gap between the autocratic and the democratic styles of leadership. The benevolent autocrat retains all of the authority of the classic autocrat but he rationalizes this as his attempt to fulfill his workers' psychosocial needs for security and stability. He retains the decision and policy making power but is prepared to listen to a limited amount of input and feedback from his subordinates. Distinct hierarchal levels in the work unit are maintained.

The literature (Bass, 1960; Beal, 1962; Kane, 1975; Brill, 1976; Bennis, 1961) explicates the positive and negative effects of each leadership style. Very briefly, autocratic leadership whereby rigid policies and procedures are implemented from the top of the hierarchy down with little regard for subordinate's needs or abilities, often results in member irritability, hostility and aggression which is directed towards both their leader and their team mates. When the leader is absent, the team produces little action, however, if rapid decisions must be made, the autocrat makes them quickly and takes full responsibility for them. The laissez-faire style of leadership frequently results in confusion and a lack of productivity. As a result, members become disinterested and apathetic towards the team and its goals. The benevolent-autocracy style of leadership produces results similar to the autocratic style, but there may be some satisfaction experienced by those team members who seek routine, and reduced responsibility. Generally however, professionals do not possess these needs; rather, they seek a fairly high level of autonomy and self actualization. They become frustrated and angry with the restrictions (Perrow, 1973).

Democratic leadership of teams is considered to be the most desirable (Kane, 1975; Brill, 1976; Wise, 1974; Horwitz, 1970; New, 1972). This style is felt to result in greater motivation of the members towards accomplishing team goals as they are given responsibility at all levels in the work process. Beal (1962) notes that individuals show less discontent, frustration and aggression and exhibit more initiative when under a democratic leader.

Finally, leadership can be viewed as a role. A team may have one designated leader or many rotating leaders or acts of leadership (Wise, 1974; Kane, 1975; Brieland et al, 1973; Brill, 1976) but no team (group) is leaderless according to Rubin & Beckhard (1972) for if no formal leader is appointed by the host organization or by the team itself, an emergent leader will arise out of the team process (Brill, 1976). In fact, both an emergent and a designated leader may exist in one group but their collaborative functioning is considered vital to team performance. As Horwitz (1970) notes:

"Leadership in team practice situations involves facilitating the achievement of common goals . . . the leadership of the team is lodged in the person or persons who can effectively influence the activity of others as they strive to achieve group goals."

(Horwitz, 1970, p. 18)

"In many teams, leadership devolves upon the individual whose profession dominates the organization under whose auspices the group practices."

(Horwitz, 1970, p. 19)

Newer team models are experiencing leadership appointment which varies from formal or emergent leadership and is known as situational or rotating leadership (Brill, 1976). In this case, the leader changes with the task at hand. The team member with the greatest skill and knowledge in the particular area which is confronting the team, will provide the

leadership. This leader does not perform all the functions of the appointed team leader, rather the normal day to day administrative responsibilities are maintained by the formal leader. Some teams adopting shared leadership have formally appointed team managers whose function it is to perform administrative chores (Kane, 1975; Horwitz, 1970; Brill, 1976). Kane (1975) and most if not all other team experts feel that this is probably the most effective style of leadership for any team practice.



## WORK PROCESS II. Role Definitions

Role, as defined by Zander, Cohen & Stotland (1957, p. 7) is "the product of many expectations concerning the functions that a given person will carry out." Brill (1976) has used a similar definition in her work but has made it more precise. She says that role "is the sum total of the behavior expected from a person who occupies a particular position and status in a social pattern" (p. 83). She adds that "position" refers to the place occupied in that pattern and that "status" is the rank or importance of that place. For our purposes, the social pattern referred to is the team.

A number of characteristics of a role are implied in this definition. It is implied that an action or behavior will occur for each person in a role. It is also implied that interaction will occur with others and that these others will have expectations about how a role shall be played. It is further implied that some decision will be made about what each role's behaviors will be, through interaction between the role player and relevant others.

It is not always easy to fit others' expectations of what a role should be. Each team member exists in many social systems and therefore, plays many roles. The behavior exhibited in any one role is determined by a number of variables (personal background, values, beliefs, the influence of relevant others, etc.) and is not always compatible with other roles played. When there is conflict between roles, the role player will strive to relieve this stress by opting for the role which is most acceptable to him. His choice will largely depend upon which reference group holds the most influence over him. In this case, does the membership on a team hold great importance to him? If not, the new

member may choose to reject the demands of his new colleagues and leave the team or at least withdraw his commitment from it.

Ideally, each role on the team should be flexible to accommodate personal differences between role players. This does not mean that a new member won't have to cope with other team members expectations of him. He will still have to find a solution to satisfy his own expectations in relation to the expectations of his new co-workers. This process of finding an acceptable and appropriate niche is referred to as role negotiating and bargaining by J. J. Horwitz (1970).

The determination of an appropriate and acceptable set of behaviors for a role by the role player is further complicated in interdisciplinary team practice as the roles of each member do not always lend themselves to clearly defined role boundaries. Frequently roles overlap; thus a constant process of role bargaining and negotiating will have to take place in order to redefine the various team roles as the task at hand changes. This implies that a process of perpetual give and take between team members must exist and that conflict between role players about their roles is not an uncommon occurrence. Unclear roles, overlapping of roles, and the lack of clear role boundaries with regard to individual task and responsibility areas are frequently cited in the literature (Brill, 1976; Kane, 1975; Horwitz, 1970; Wise, 1974; Beckhard, 1972) as chief sources of team conflict.

Bernard and Ishiyama (1960) deal specifically with this concern by delineating between what a role is prescribed as being, i.e., the assigned authority of the role, and what the individual is capable of and is permitted to do, i.e., the achieved role. They state that role conflict is really intrastaff and intraindividual conflicts engendered

by certain configurations of motivation, assigned authority and achieved authority (p. 73).

Attempts have been made to avoid or at least reduce role conflict by clearly identifying role sets prior to the filling of a team position. These attempts have largely been unsuccessful as it is very difficult to commit the role expectations for each position to paper. The result is usually an inflexible, restrictive and dysfunctional job description, which does not allow for personal changes one may wish and is capable of making in a position. It has been found to be more useful to look at a job as "a man in action" (Beckhard, 1972, p. 112) and to refrain from using restrictive job descriptions.

The literature reviewed pointed to three roles that are played by members of modern interdisciplinary medical teams. They are the specialist role, the generalist role and the leadership role. Brill (1976) deals with this phenomenon more precisely than most authors but she is not alone in describing these roles. She describes the specialist role as being defined according to the possession of particular knowledge and skills. This role could be filled by the physician, the psychologist, the social worker or the nurse. The generalist role is seen as a case manager. He is most often the liaison between the client and the team. This role may be played by many but is most often assigned to the social worker and/or the nurse. The leadership role is related to the structure of the team, the requirements of the host organization (under whose authority the team functions), and the personal abilities of the team members (see Work Process I). Traditionally this role has been played by the physician but new studies into the advisability of this appointment have favored a leader appointed on a basis of ability, rather than on professional membership.

In looking at the interdisciplinary teams in terms of role descriptions, it is becoming less and less sufficient to state that a team member's professional alliance defines his role. One's professional status does however, provide an indication of task functions, responsibility relations and normative relationships which are expected of an individual by relevant others (Zander et al, 1957). Zander, et al (1957) refers to these expectations as "prescriptions for a role" (p. 15).

Team members must learn to work together as a cooperative and organized unit in order for the stated goal of health teams (a return of the individual to his highest level of functioning) to be pursued effectively. For this to occur, each team member must have a clear understanding of what his own contribution to the team's effort could be. As well, he must have an equally clear recognition of the other professional member's contributions (Drew, 1953; Robinson, 1953). Means (Drew, 1953) has referred to this as "clinical maturity". He notes that at this stage, insight, a sense of proportion and practical wisdom is achieved on the part of the team as a whole and on the part of each team member.

The medical interdisciplinary teams that are referred to in the literature generally consist of specialists: physicians, psychologists, social workers and nurses in varying numbers. Traditionally the team is structured in a hierarchy of a pyramidal shape with the physician being at the apex and the nurses, psychologists and social workers at the base. The roles are generally assigned from above with the role sets being prescribed on a basis of professional association. The physician is the traditional leader and is usually formally appointed by the host organization. He generally has considerable authority and responsibility which is given to him largely in view of his professional status, both on the

team and outside the team, his academic background, his area of expertise, and the legal responsibility for the team's actions which he is felt to be ultimately responsible for. His personal attributes and preparedness to assume the leadership are not generally taken into account in determining his role. Traditionally the physician is treated with deference and even awe by the other helping professionals and therefore, extensive role bargaining is not usually involved in determining his role set. His areas of responsibility may involve administrative duties, supervisory and educational duties, plus ultimate decision-making for diagnostic and treatment procedures.

The roles of the other member on the interdisciplinary team on the other hand, may be prescribed for them to a very large extent either by the host organization or by the physician who is responsible for developing the team. Each role set is most often determined on the basis of membership in a specific profession.

Zander, et al (1957) seems to feel that there is a degree of understanding by professionals about other professional's values, skills and expertise. Most authors do not support this belief. They all, however, recognize the desirability of such an understanding. A lack of understanding and respect for professional colleagues in combination with unclear role definitions can, and often does, lead to team members becoming suspicious of their co-worker's intentions and motives. In defence, each specialist may become overly protective of his assumed territory. A team such as this runs the risk of becoming self-centred and dysfunctional (Rehr, 1974; Robinson, 1952).

Kane notes that "One of the strengths of the interprofessional team, at least in theory, is its ability to bring to the task the varying

perspectives and orientations derived from the several professions involved" (p. 16). However, she adds a note of caution, "the protectiveness of professions and the sense of territoriality in the face of genuine but at times unacknowledged common areas of interest produces difficulties for the professional working in a setting where no traditions for his profession yet exist" (p. 16).

It would seem that it is important to recognize one's own professional worth but it is equally important to realize that no one profession has a priority place on the interdisciplinary team. By definition, interdisciplinary team practice calls for a recognition of the worth of multi-disciplinary contributions to service delivery or task completion. If the common goal is kept in mind, each member should be allowed to determine what his role should be in terms of where he could contribute the most (Butrym, 1967, p. 78). He should be prepared to allow his colleagues the freedom to do the same.

### WORK PROCESS III. Communication Processes in the Team

"The essential ingredient in working successfully with people is the ability to establish meaningful communication with them" (Brill, 1976, p. 64).

Brill (1976, p. 65) indicates that communication can be defined according to content, as the transfer of meanings, or according to process, whereby, through the exchange of messages, a channel is created within which interaction can take place between and among people. Structurally, therefore, communication is the pattern of "channel linkages" among individual members of a group (Fischer, 1974, p. 158). The usual linkages made within a group defines their communication pattern or network.

Mechanically, Fischer (1974) notes, the necessary components in any communication are the sender of a message, and the receiver of that message. The sender delivers a message, the receiver decodes it, reacts to it and sends his response to it (feedback) back to the sender. He adds that the communication may be either verbal, non-verbal or written in nature but will always contain both overt and covert messages. At one level, the communication conveys content and meaning and at another level, it tells the receiver how to interpret the message sent. Likewise, the receiver may respond to the content of the message and/or to the intent of the message. His perceptions about the message and the value which he places upon it will determine how he receives and reacts to it. His perceptions are influenced by his past experience, his relationship with the message sender, his feelings and his attitudes as well as the circumstances he is presently experiencing.

Messages are generally placed in one of two categories - station-to-station or person-to-person. Station-to-station communication typically lacks feeling and is related only to one's working role. The latter messages, person-to-person are those in which the emphasis is on emotions, not roles (Horwitz, 1970, p. 78).

As noted earlier, the medical model of teamwork is noted for its use of formal, station-to-station communication with messages flowing from the top of the hierarchy down to the bottom. This is commonly referred to as a vertical communication network. Horizontal communication is less formal and occurs between members of equal status.

The communication pattern adopted by a work unit is influenced by the member's social status and their role structures. Who speaks, when, how, to what purpose, and to what effect is determined by how the group is structured (Brill, 1976, p. 68). Fischer (1974) suggests that centralized communication patterns, wherein all messages go through the leader, will produce satisfaction at the centre of the group but not at the periphery. Task efficiency and coordination of contributions, however, is promoted and the formal leader's authority is clearly established but centralized communication discourages feedback and consequently, discourages criticism of the leader, his management style and his decisions. As a result, there is a risk of error in understanding and problem solving.

The same literature notes that teams which adopt a less centralized communication pattern seem to experience greater worker satisfaction, group cohesiveness is enhanced and complex tasks are more easily performed (Fischer, 1974, p. 161). Brill (1976, p. 69) suggests that the healthier the climate of the team, the greater the occurrence of casual, decentralized, one-to-one conferences between team members.



Kane (1975) indicates that while there is no one communication pattern that is best suited to every work unit it is suggested that the most appropriate network for team practice might be that of the centralized model with the opportunity for feedback, as this pattern would seem to combine the most salient features of both the centralized and decentralized models. This, along with the use of a common language (not the adoption of one profession's jargon) and common record keeping by the team is felt to promote work efficiency and worker satisfaction (Kane, 1975).

## WORK PROCESS IV. Decision-Making and Problem Solving Processes in the Team

"A group is a problem-solving, decision-making mechanism."

(Rubin & Beckhard, 1972, p. 313)

By definition, the interprofessional team is a group of many professionals who have input into team decisions. While there is no simple formula or rule for making decisions effectively, Thelan (1970), and Hall (1971) suggest that a group (team) can reach a better, more appropriate decision than can an individual. However, Kane (1975) notes that in most team practices there are no clearly defined decision-making procedures.

The type of decision-making which prevails on any team is generally dependent upon the style of leadership adopted by the formal or informal leader (Kane, 1975). He may choose to make all decisions himself, to delegate his authority in specific areas and to retain it in others or to share the entire decision-making process with some or all of the team members.

Kane (1975a), Horwitz (1970b), and others indicated that there are two types of decisions which must be made which involve the team - those with which the whole team is involved, and those with which a subgroup of the team is involved. These authors label these respectively as team decisions and task decisions. Beckhard (1972) suggests that only those team members who are closest to the problem and who have the most knowledge about it need be involved in making task decisions.

Beckhard (1972) suggests that ideally those who should be involved in making a decision can be determined by answering these questions:

- 1) Who has the necessary information to help make the decisions?
- 2) Who must be consulted before the decision can be reached?
- 3) Who should be informed after the fact?"

(p. 319)

This implies that only those with expertise in the particular problem area and those who will sanction the decision need be consulted to make some decisions. Decisions that affect the entire group eg. policies and procedures, should be decided upon by the whole team in order to encourage a common commitment to them (Beckhard, 1972). But, not all decisions which affect the team are made at the team level. Some decisions which affect the team are made at the administrative level of the host organization. Ideally, Brill (1976) indicates, any decisions that are made which affect the team should involve representation from the team, but in reality, if the team is even represented in the making of these decisions, the representative will probably be the team leader. In such a situation, the leader is caught in the unhappy circumstance of being both a team member and an administrator. It is suggested that in this dual role, he will be unable to do justice to either position without sacrificing the other. This stressful situation has been recognized in some organizations and has been successfully overcome by the appointment of a team manager who is responsible only for team administrative duties.

The selection of a "decision is the climax of the whole process" of decision-making (Fischer, 1974) and an understanding of the decision-making process must include a look at how the decision is actually arrived at. Wise (1974, p. 126) describes decision-making as the outcome of the group interaction whereby a choice is made by the group members from among alternative proposals available to them. The literature examines how the decision is arrived at.

Edgar Schein (1969) has identified six methods which have been widely accepted as representative of means by which team decisions are made. Schein writes that decisions are reached through: 1) lack of response, 2) authority, 3) minority, 4) majority, 5) consensus, or 6) unanimous consent.

Schein explains each decision process briefly and is supported in his observations by Kane (1975), Brill (1976), Brieland et al (1973), and Wise (1974), as well as other students of team practice. Decision-making by lack of response is represented as one of the least desirable methods as it is seen as an indication that the team is in trouble. The lack of response may signal withdrawal and apathy on the part of the team members.

Decision-making by authority is said to occur when the leader decides a choice of action without participation of the other team members. Such independent action may be appropriate in some instances but Schein indicates that it is not generally considered conducive to the maximum development and usage of the team unit.

Schein describes decision-making by a minority as that which occurs when a small group of team members make the team decisions regardless of their peers' ideas. This method is considered undesirable by Schein, Kane and others as they feel it may be an indication of an abuse of power and status by some and for a feeling of powerlessness by others. These authors indicate that the result of such decision-making is a lack of commitment to "team" decisions by all team members.

A fourth pattern of decision-making according to Schein is decision by the majority. He indicates that this is a commonly accepted practice involving a vote by the total team membership on a choice of

possible actions. The course of action which receives the majority of the votes is adopted as the group decision. Kane (1975) cautions that while this practice can serve as a short-cut in making decisions, there is no guarantee that the decision made is the best or the right decision.

Decision-making by consensus is touted by Schein and many other organizationalists and team specialists (Horwitz, Kane, Brill, Fischer, etc.) as the best decision process. It entails extensive group discussion of the issues aimed at finding a solution which is acceptable to everyone. There is an understanding that the whole team will accept and abide by the decisions of the group even if they have some reservations about them. Schein indicates that the successful use of consensus is a measure of a high level of maturity on the part of the team.

Finally, decision-making by unanimous consent is considered by Schein to be an indication of an actual universal agreement of the team members or may merely be a token show of team unity. When the unanimous consent is an example of genuine universal agreement, this process is considered to reflect a high level of team functioning.

## WORK PROCESS V. Definition of the Team's Purpose

"Any team or group has a purpose." (Wise, 1974, p. 34)

Formal organizations which are sometimes referred to as instruments for attaining goals (Scott, 1974, p. 7) are commonly comprised of smaller departments which are responsible for carrying out segments or subgoals of the larger organizational goals. While most organizational theorists stress the importance of defining specific organizational goals (Scott, 1974; Wise, 1974), few health care organizations follow this practice (Wise, 1974). Their goals are usually stated in broad, nonspecific phrases such as "the promotion of health and the prevention of illness" (Scott, 1972). Such a goal does not lend itself to easy measurement or commonality of interpretation. This ambiguity often results in conflict over the tasks to be undertaken, the personnel needed to accomplish the tasks, the status and authority of the needed personnel and the methods for achieving the goals. A more precise, easily operationalized goal would help to alleviate or even prevent such conflict (Scott, 1972).

As noted previously, most organizations consist of smaller units whose responsibility it is to carry out segments of the larger organizational goals. The health team is an example of such a department and nowhere is the need for specificity of goals more relevant than in this group of interdisciplinary professionals with their variety of skills and ideological stances. Specific goals are essential in order for the team members to pursue a common purpose (Horwitz, 1970, p. 83). As the reader may recall, the very definition of teamwork specifies that the team has a common purpose.

The literature pertaining to organizational and group goals and purposes is very confusing in its lack of discrimination in the use of these terms. Brill (1976), however, in her book "Teamwork", states that goals arise out of the purpose and become the intermediate and complementary steps taken on the way to the achievement of the purpose (p. 124). Similarly, Scott (1974) notes that "goals are only concepts of desired ends" (p. 8). The team is responsible for visualizing the goals and for setting priorities among them. The goals must be "specific, realizable and preferably exist on a timetable" (Kane, 1975, p. 124).

Brill (1975) states that the purpose of the team, as opposed to its goals, arise out of the careful examination of the definition of the problem facing the team. The purpose determines the structure of the team, its composition, its size, and its working method. Again, the team's purpose, the reason why it was formed in the first place, must be shared, understood and agreed upon by all of its members, not just a select few.

The method used and plan of action used to achieve these common team goals and its overall purpose are called the team's objectives - the "blueprint for action determining specific targets to which energies and resources on the team will be directed" (Brieland, Briggs & Luenberger, 1973, p. 26). The objectives should also be developed and agreed upon by the entire team at the time of the formation of the unit and potential members of the team should be fully oriented to the organizational team goals, purpose and objectives before they are asked to make a commitment to them. New members to the team must be likewise oriented for it must be remembered that individual team members may have specific personal goals which could conflict with organizational and team goals. Orientation of

the potential team member to the larger goals is aimed at preventing such conflicts. If there is a discrepancy between the two, the individual team member must take responsibility for either accommodating the difference or else electing not to join the team. Failure to do so will result in conflict, frustration and anxiety for the individual and will be antithetical to the development of overall team unity, cohesion and solidarity (Briscoe, Thomas, 1973; Jay, 1972).

The literature is quite clear in its emphasis on the importance of clear, specific and commonly understood and agreed upon team goals yet it notes that most teams experience considerable uncertainty over goals and purposes. This confusion and uncertainty results in worker anxiety, frustration, lack of direction and ultimately ineffectual and contradictory service delivery (Pringle, 1978; Rubin & Beckhard, 1972; Brieland, Briggs & Luenberger, 1973; Brill, 1976; Luzski, 1968; Jun, 1976). Raven and Reitsem's (1966) research directly links clarity of goals with an increase in attractiveness of the group for its members, increases in task-related activities, reductions in hostile feelings to other members, and an increased sense of belonging.



## WORK PROCESS VI. Conflict Resolution Processes in the Team.

The term "conflict" implies a negative connotation of quarreling and squabbling and as a result, is often regarded as an undesirable occurrence. In reality, conflict may merely refer to a minor or major difference in opinion which does not call for an aggressive resolution. When handled properly, conflict is thought to promote growth and understanding.

Conflict is a natural and inevitable occurrence on an interdisciplinary team (Fischer, 1974; Kane, 1975). Brieland et al (1973) cites three main types of conflict that a team may experience, those that arise from three sources, (1) the internal needs of the team, (2) the demands of the external environment and (3) the quality of leadership (p. 27). Such conflicts are also referred to as intragroup conflict, intramember conflict, intergroup conflict and conflict over leadership issues.

Intragroup conflict refers to differences that arise between members due to their varying values, attitudes, points of view and approaches to working. Intramember conflict occurs when an individual member's values, goals and ideologies conflict with those of the teams. Intergroup conflicts are those which result out of differences that occur between the team and other groups, eg. community vs. team, host organization vs. team, clients vs. team, and so forth. The other source of conflict which Brieland et al (1973) refers to involves poor quality of leadership and dissatisfaction with goal achievement (p. 27).

Fischer (1974) and Bernstein (1965) note that conflict, when it does occur, is dealt with in a variety of ways, either constructively



or destructively. They indicate that intragroup differences can be resolved by the domination of the team by the stronger members, compromise solutions, bargaining, appeasement, negotiations and mediation or by integration (i.e. team goals rather than individual goals are pursued). Fischer advocates for the latter constructive resolution of intrateam conflicts.

At an individual level, internal conflicts can be resolved by either acceptance, or rejection of the team's stance. The individual strives to relieve the tension he experiences as a result of conflict and will either reframe the team's solution to make it more acceptable to him or outrightly reject the team. The individual, if regarded as a valued member of the team, will experience considerable pressure from his teammates to conform to the team norms. If the member is considered to be less than valuable by the rest of the team, he will be ignored or ostracized.

Inevitably, each team will develop unique attitudes and norms for handling team conflicts. Stephen Robbins (1974) has suggested that there are essentially three attitudes toward conflict: 1) conflict is dangerous and must be eliminated, 2) conflict is inherent in groups, but must be resolved, or 3) conflict is vital to the growth of the group if it is managed effectively. Fischer (1974) adds to these points. He indicates that ignoring or suppressing differences is a destructive coping technique as the end result is merely camouflaged conflicts with no attempt to work through the problem(s). He feels that member hostility and frustration will occur and in the long run will prevent maximum team development from occurring. Resolution of conflicts through open and honest discussions of differences, Fischer feels, will promote team

cohesion as together the members strive for alternate and more acceptable plans of action. The team goals rather than the goals of a few are pursued, and as a result, total member commitment to the new solutions will be greater.

Once a team establishes a history of successfully resolved conflicts, it can cope more effectively and easily with subsequent conflicts. Suchman (1963) suggests a program for reducing conflict on teams which could help to establish such a history:

- a built-in process for review of decisions,
- opportunities for each member to develop a working knowledge of each other's field through planned mutual instruction
- role clarification whenever possible, and
- improvement of the interpersonal skills of the members (p. 197)

It would appear that every team will experience conflict. If it is poorly handled or ignored, it would seem that the team may fail to reach its goals. It may experience outbursts of anger and hostility between its members and will begin to set up patterns of "perpetuation of basic mistrust and misunderstanding" (Hietner, 1957). However, if the conflict is handled well, Fischer (1974) suggests that the team will come to regard conflict as a potential catalyst to its growth and development and will then openly work through troublesome issues. Fischer (1974, p. 107) also indicates that learning to cope with internal and external conflict will increase the team's flexibility and cohesion. He feels that the team which does not experience a healthy degree of conflict will accept mediocre problem solutions and will not grow or progress towards its goals.

WORK PROCESS VII. The Interactional Processes of the Team and Its  
Environment (i.e. host organization)

Interdisciplinary teams are most usually sub-units of some larger agency or organization and the importance of the team's interactions with its host organization cannot be stressed enough. Naomi Brill (1976) has emphasized the importance of recognizing and dealing with this relationship in the introductory paragraph of her chapter The External Life of the Team, in Teamwork (1976).

"A team does not operate in a vacuum. It is both a total system within itself and a component of larger systems. As such, its second major responsibility (after dealing with itself) lies in dealing with a triple set of environment relationships: 1) relationships with the other sub-systems within the host organization, 2) relationships with the organization itself, and relationships with the overall community. This triple responsibility leads to an exceedingly "complex set of give-and-take relationships", the nature, intensity, and demands of which depend on the situation of the team, its basic purpose, and the part it is designed to play in the overall picture. The definition, establishment, and the maintenance of these relationships constitute an essential part of the team's work" (p. 103).

Brill (1976), along with Horwitz (1970), Wise (1974), Kane (1975) and many other students of team practice, notes the complex issues and problems that can arise from the intimate relationship between a host organization and one of its subunits, the interdisciplinary team. Each system exists within certain boundaries and as such "the interfaces between systems and subsystems, the points at which the boundaries touch, are areas crucial to effective functioning. The linkages that the system constructs across these interfaces will play a significant part in the subsystem's ability to work in unity" (Brill, 1976, p. 110). Brill indicates that these interfaces are characterized by competition and collaboration but also by conflict over different values, allocations of rewards and resources, and over threats to existence.

Horwitz (1970) would seem to support Brill's observations. He notes that bureaucratic administrative procedures in the organization of which the team is a part will necessarily be reflected in the team's own operating methods as the systems for authorizing activities and reviewing their outcomes must both mesh with the way such matters are dealt with at higher organizational levels (p. 89). This does not mean that the meshing will be automatic nor without conflict.

Conflicts between host organizations and their interdisciplinary teams arise out of many issues.

Organizations have their own "life-styles" (Brill, 1970, p. 90) and operations at the team level will be affected by this as well as by the structural style of the host organization. The quantity, form, frequency and accepted channels of communication are frequently set by the larger organization as are goals, salaries, hiring and firing of personnel, job descriptions, and to a lesser degree, policies and procedures. Each of these areas can be a potential source of inter-systems conflict.

Traditionally, large complex organizations have been hierarchal and rigid in structure but modern organizations less and less frequently follow this pyrimidal power structure (Brill, 1976, p. 105, Horwitz, 1970, p. 97). Rather, according to Brill and Horwitz, they have evolved into a cluster of interacting and interrelating systems. The modern team in human service is only one aspect of the whole within this new structure. There is some room for decision based on professional judgements. The host organization still advances general policy which is to be followed, but which the team is allowed much input into the way the policy is instrumentalized. As Horwitz (1970) notes "much remains to be

learned about the ways in which the team accounts to the host organization, but it does appear clear that the salient controls over practitioners are for the most part exercised by the team. Where the leader exercises such authority, it is couched largely in the language of responsibilities not to the complex organization but to the interdisciplinary team and its clients" (Horwitz, 1970, p. 98).

As already noted, team literature indicates that problems between the organization and the team can arise over many issues. One problem which has not yet been cited but which is responsible for a great deal of conflict arises when workers are simultaneously members of an interdisciplinary team and of the staff of a functional department in the host organization. Horwitz (1970) suggests that such workers should be responsible to the team's leader and to their team colleagues, with no dual allegiance to any executive or administrator elsewhere in the larger organization. He further suggests that in situations where "one particular profession is, or has been, dominant in a setting, workers in other professions may feel a need for one or another departmental organization, and a "chief" in their own disciplines as a protective power centre and a focus of distinctive professional identity" (p. 98-99).

Horwitz (1970) notes that just as the team is affected by the host organization, the team also has the potential to influence its host organization. In this regard, Brill (1976) suggests that the negotiations between the host organization and the team should be ongoing. The success of such negotiation would appear to be contingent on the manner in which following four concerns are dealt with:

1. Purpose: there must be a clear commitment to the overall organizational and team purpose. The commonalities and differences in the contributions of each must be recognized.

2. Communication: there must be specific provisions for channels of communication (both written and personal contacts) between the host organization and all of the team members.

3. Decision-Making: there must be some provision for the exercise of judgement by each team member whose expertise in their own area is such that this is both desirable and necessary. The team member will make judgements taking relationships among the team, the organization and the overall organizational policy into consideration. Likewise, the team should not be expected to implement policies in which it had no voice. The hiring and firing of team personnel should be done with input from relevant team members.

4. Accountability: there must be some provision for the accountability of the team to its host organization as well as a built in evaluation procedure for the team (Brill, 1976, p. 111-114).

### WORK PROCESS VIII. The Team's Functional Use of Group Process.

As noted previously, the team is a task or work group (Beckhard, 1972) and as such, is subject to the usual processes of group development and group maintenance. Koop (1977) sites Schein (1969) as stating that for a work or task group to function effectively, it must deal with three types of group behaviors: 1) self-orienting behavior, 2) behavior directed at building and maintaining itself, and 3) behavior directed at accomplishing its work. We shall focus on behaviors for team maintenance and task completion.

The leader plays a vital role in both the maintenance of and the productivity of the team. Accordingly, leadership of the team has been described as a combination of goal-directed abilities and interpersonal skills (Kane, 1975). The responsibility for group maintenance and task completion does not lay only with the leader rather as Kane (1975) notes, any professional who wishes to facilitate team productivity cannot ignore interpersonal relationships, but must also be aware of the task focus of the group" (p. 46).

The data on harmony and its association with team effectiveness are complicated and somewhat contradictory but it seems clear that a team must strike some working relationship between its emphasis on harmony and its emphasis on task completion for without one or the other, it is felt that the team will not reach its full potential for team development (Wise, 1974; Kane, 1975; Brill, 1976; Beckhard, 1972; Horwitz, 1970).

Wise (1974) indicates that for a team to be effective, a major part of the group's energies must be focused on the task at hand and that that task is accomplished with a minimum amount of energy being invested



in maintaining the group morale, and member satisfaction. Similarly, Rubin & Beckhard (1972) describe a team's ability to do its work and to manage itself as an independent group of people as their effectiveness or their level of maturity.

Team effectiveness depends upon many variables, the development of a normative and value system, healthy problem solving, etc., but in all of these variables, the need for effective communication is clear. Brill (1976) indicates that work progression and problem solving through the team model depends on the mastery of two basic skills: the use of meetings and the use of their essential corollary, discussion. She adds that "the misuse of these two fundamental skills is at the root of many of the classic complaints about the team model - that it is a time-consuming, unwieldy, and unable to act. Brill (1976) argues that "these problems are not inherent in the team model but rather arise from a lack of knowledge and ability to use meetings and discussion wisely and with maximum effectiveness" (p. 127).

In terms of group maintenance, Brill (1976) feels that the effective team possesses unity, cohesion and solidarity. She notes that the development of these qualities depends again upon the team's success or lack of success in developing its own value and normative systems. A team is a collection of individuals and only that unless it can draw together in a feeling of oneness. Its members must be able to work together in spite of internal and external pressures.

#### IV. CONCLUSION

Wise (1974, p. 96) summarizes all concerns about a team's level of functioning in his claim that productivity and team effectiveness can be measured by the degree to which the dimensions listed below exist:

1. Clarity of objectives and mission
2. "Good" decision-making and problem solving processes.
3. Clear role expectations.
4. Norms that support the task.
5. Concern for each other's needs.
6. Optimizing resources for growth and enlarging individual jobs.

Wise's (1974) summary comments lend importance to the previously outlined work processes. He implies that all of these variables are important to the successful functioning of team practice. Although those stressing the need for research into individual team practices (Kane, 1975; Brill, 1976; Wise, 1974; Horwitz, 1970) stress the desirability of limiting this extensive list of variables, they admit that it is too early in the research process to do this with any degree of comfort and validity.

#### IV. SUMMARY

This chapter has presented an historical precis of the team practice as well as its advantages and its disadvantages. It has described various models of team practices and has outlined in some detail, the work processes to be examined in the study of the C.D.C. team practice. Chapter III shall now present the research design and methodology incorporated in this study.

## CHAPTER III

### METHODOLOGY

#### I. The Subjects

The subjects chosen for this study consisted of all twelve C.D.C. team members (excluding their support staff ie. four secretaries) and a client sample consisting of twenty-three new cases opened at C.D.C. during the month of March 1980. Specific demographics of these subjects is presented in Chapter IV.

#### II. The Instruments

The purpose of this study is the exploration of one team's practice. The following areas will be examined:

1. the team's work processes,
2. its strengths and weaknesses, and
3. its clients' perceptions of the team's effectiveness.

The Staff Interview Schedule will be used to accomplish the first task, the Team Effectiveness Diagnostic Instrument to accomplish the second task and the third task will be accomplished using the Supplementary Sheets and the Client Evaluation Questionnaire.

##### A. The Staff Interview Schedule

A structured combination open-ended and closed interview schedule (see Appendix B) was developed for the purpose of this study. The eight work processes suggested by Horwitz (1970) and developed by Koop (1976) were used as a guideline in the formulation of the subject areas and the specific questions. Questions in each of eight areas - leadership, communication, problem solving, decision-making, task assignment, team purpose, conflict resolution and the team and its' environment - are

intended to obtain each member's perceptions of the team's structure and work style.

B. Team Effectiveness Diagnostic Instrument

The Team Effectiveness Diagnostic Instrument (Rubin, Plovnik and Fry (1975) (see Appendix C), is used to identify the problem areas in this team and to assess the level at which the team is functioning. Its secondary function is as a validation check of the Staff Interview Schedule.

The instrument presents the team member with eight scales each of which consists of two statements. The respondent must decide how closely the statements apply to his team. The scales deal with goal clarity and conflict, role ambiguity, role conflict, member participation and influence in decision-making, commitment and understanding of team decisions, conflict management, inter-member recognition and respect, and team cohesiveness.

As this instrument is relatively new and has not been widely used in research to date, statistics on its validity and reliability are not available. However, it is used in this study as no other instrument specifically designed to assess a team's level of functioning has been developed.

C. Supplementary Sheets

Supplementary Sheets (see Appendix D) were developed to supplement the Client Record Sheets (see Appendix D) used on all client files at C.D.C. The forms are designed to identify the primary focus of the care given to each client as well as to identify the team members involvement with each case.

#### D. Client Evaluation Questionnaire

A Client Evaluation Questionnaire (see Appendix E) was developed specifically for this study. These structured, combination open-ended and closed questionnaires were mailed to the client sample. They are designed to obtain individual client's perceptions of the help they have received, their satisfaction with that help as well as their suggestions for improving the service provided by C.D.C. staff. (Due to the age of the clients 0-7 yrs. it is necessary to include their families in this evaluation.)

#### III. The Procedure

The Director of C.D.C. was approached and permission was granted to allow this study of his team. The team members were then approached and agreed to co-operate with the study.

The client sample of twenty-three was selected under the criteria that cases be: 1) new to the Clinic during the month of March 1980, and 2) involved with more than one team member. Table 2 indicates the sample portion as selected from all cases opened at C.D.C. during March 1980.

TABLE 2

NEW CASES OPENED AT C.D.C. - March 1980

Cases Opened March 1980	Frequency of Occurrence
One team member involved	17
More than one team member involved	23
Not Useable *	7
Total	47

\* not new in March 1980, forms incomplete, etc.

Data from the team members was collected by interviewing each member separately for  $1\frac{1}{2}$  hours at the clinic. Subjects were told that their involvement was voluntary and that the responses were confidential. All team members participated giving a response rate of 100%.

Data from the client sample was collected by mailing a questionnaire, a covering letter explaining the study (see Appendix F) and a stamped and addressed return envelope to each subject. A follow-up letter was sent two and one half weeks later. The response rate was  $13/23$  or 56.56%.

#### IV. Summary

Chapter III has presented the methodology of this research thesis. Chapter IV shall present the research findings as well as the specific demographics of the staff and the client sample.

CHAPTER IV  
RESEARCH FINDINGS

I. STAFF DEMOGRAPHICS, TEAM INTERVIEW SCHEDULE AND TEAM EFFECTIVENESS  
DIAGNOSTIC INSTRUMENT FINDINGS

Due to the quantity of information contained in this chapter, the findings have been grouped into subsections which are titled according to the subjects and instruments involved.

This section shall present the demographic characteristics of the team members followed by their responses to the Staff Interview Schedule and to the Team Effectiveness Diagnostic Instrument (See Appendix B and C). These findings shall be presented in tabular form where possible and narrative form where this is not possible.

A. Demographic Characteristics of the Staff

The following information was obtained from the interview face sheets (Appendix B).

Table 3 shows that the team consists of representatives from six disciplines, one audiologist, two speech therapists, two psychologists, three physicians, two social workers and two nursery school teachers. (The support staff, four secretaries, were not included in the sample.) The sample includes the Director of the Clinic (one of the team physicians) who is also the designated team leader.

The level of education of the team members is above high school in all cases (see Table 3). Three members have community college degrees, six have Master's degrees in their respective disciplines and three have M.D.'s plus certification in pediatrics.



TABLE 3  
TEAM MEMBERSHIP

Team Member	Educational level	Length of Time on CDC team	Previous team experience
Audiologist	M.Sc.	9 mons.	-
Speech Therapist-1	M.Sc.	4 yrs.	-
Speech Therapist-2	M.Sc.	7 mons.	2 yrs.
Psychologist-1	M.A.	10 yrs.	-
Psychologist-2	M.A.	10 yrs.	-
Physician-1 (Team leader/ Director of C.D.C.)	B.Sc., M.D. and Certification in Pediatrics	16 yrs.	-
Physician-2	M.D. and certification in Pediatrics	13 yrs.	-
Physician-3	M.D. and fellowship in Pediatrics	7 yrs.	-
Social Worker-1	2 yr. diploma Social Welfare Services Program	4 yrs.	-
Social Worker-2	B.S.W., M.S.W.	2 yrs.	3½ yrs.
Nursery School Teacher-1	2 yrs. university (no degree) -Diploma (Teacher's Aid Training Course)	15 mons.	-
Nursery School Teacher-2	2 yr. diploma (Early Childhood Development)	5 yrs.	-

$\bar{x}$  = 6.15 yrs.

The mean length of time on the team is 6.15 years, with member's experience with this team ranging from 7 months to 16 years.

Two team members note previous interdisciplinary team involvement of two years and three and one-half years respectively. All other team members have no previous team experience.

## B. Staff Interview Schedule

### 1. Team Members

#### (a) Leadership

Table 4 indicates that the Director of C.D.C., is seen as the formal leader of this team. He shares the leadership with the primary therapists on each case, often in conjunction with the physician involved with the case (see Table 5 and 6). No team member is perceived as being excluded from such leadership (see Table 7).

TABLE 4  
DESIGNATED TEAM LEADER

Designated leader	Frequency of Response	Percentage of Response
Director of C.D.C.	11	91.6
Any one of the physicians	1	8.4
Total	12	100.0

TABLE 5  
OCCURRENCE OF SHARED LEADERSHIP

Occurrence of Shared Leadership	Frequency of Response	Percentage of Response
Yes	10	83.3
No	2	16.7
Total	12	100.0

TABLE 6  
MEMBERS SHARING LEADERSHIP

Members Sharing Leadership	Frequency of Response	Percentage of Response
Physicians	3	25.0
Primary Therapist with physicians	1	8.3
Primary Therapists on each case	5	41.8
Social Workers	1	8.3
All team members - casework ) All physicians - administration)	1	8.3
No one shares leadership	1	8.3
Total	12	100.0

TABLE 7

## TEAM MEMBER'S EXCLUDED FROM ACTS OF LEADERSHIP

Team Member Excluded From Leadership	Frequency of Response	Percentage of Response
No one excluded	8	66.7
All team member's excluded	1	8.3
All excluded except physicians	3	25.0
Total	12	100.0

Table 8 indicates that the formal team leader's leadership style is perceived as being democratic although it is noted that he occasionally adopts an autocratic style in administrative matters.

TABLE 8

## FORMAL TEAM LEADER'S LEADERSHIP STYLE

Leadership Style	Frequency of Response	Percentage of Response
Autocratic	-	-
Laissez faire	1	8.3
Democratic	7	58.4
Other:		
-Democratic with some autocratic	3	25.0
-Combination of autocratic, laissez-faire and democratic	1	8.3
Total	12	100.0

The C.D.C. team is perceived as having an informal as well as a formal team leader. This role is felt to be played by another physician who has been on this team for thirteen years (see Table 9 and 10).

TABLE 9  
EXISTENCE OF AN INFORMAL TEAM LEADER

Existence of Informal Leadership	Frequency of Response	Percentage of Response
Yes	10	83.3
No	2	16.7
Total	12	100.0

TABLE 10  
MEMBER'S ACTING AS INFORMAL LEADERS

Informal Leader	Frequency of Response	Percentage of Response
One particular physician	6	50
Depends on the case	2	16.7
Any one of the physicians	1	8.3
One Social Worker	1	8.3
No One	2	16.7
Total	12	100.0

50% of the team members do not wish to take a more formal role in team leadership. However, Table 11 indicates that those members who would like more involvement in the formal team leadership are the speech therapists, one psychologist and one nursery school teacher.

TABLE 11

TEAM MEMBER'S DESIRE TO LEAD THE TEAM AS  
RECORDED BY FREQUENCY OF RESPONSE

Discipline	n	Desire to lead				
		strongly like	like	undecided	dislike	strongly dislike
Audiologists	1	-	-	-	1	-
Speech Therapists	2	-	2	-	-	-
Psychologists	2	-	1	-	1	-
Physicians	2*	-	-	-	1	1
Social Workers	2	-	-	1	1	-
Nursery School Teachers	2	-	1	-	-	1
Total responses	11	-	4 (33.3%)	1 (8.3%)	4 (33.3%)	2 (16.7%)

\* Team Leader's response not recorded

The formal team leader's emphasis in leading the team is perceived as being on a combination of: keeping the patients happy, keeping the team members happy, task completion and teaching staff, patients and the public (see Table 12).

TABLE 12  
THE FORMAL LEADER'S EMPHASIS AS RECORDED BY FREQUENCY OF RESPONSE

Discipline	n	(a) task completion	(b) keeping team members happy	Leader Emphasis (c) keeping patients happy	(d) equal emphasis on a,b,c	(e) other*	* Other (i) & c	(ii) a,b,c & teaching	(iii) a & c
Audiologist	1	-	-	-	-	1	1	-	-
Speech Therapists	2	-	-	-	2	-	-	-	-
Psychologists	2	-	-	-	1	1	-	-	1
Physicians	3	-	-	-	1	2	-	2	-
Social Workers	2	-	-	1	-	1	-	-	1
Nursery School Teachers	2	-	-	1	-	1	-	1	-
Total	12	-	-	2 (16.7 %)	4 (33.3%)	6 (50%)	1	3	2

(b) Team Member's Roles

Table 13 indicates the roles played by the various team members. It indicates that there is a strong agreement on this team between the real and perceived roles played by its members. The members generally feel that their roles are flexible and negotiable rather than rigid and non-negotiable (see Table 14).

Table 15 describes who is involved in role negotiation. It is noted that some members need only negotiate with C.D.C. personnel while others must negotiate with both C.D.C. personnel and with their respective departments in the larger Health Sciences Complex in order to change their responsibilities.

Table 16 indicates that 66.7% of team members feel that their roles overlap a great deal. Table 17 indicates which roles overlap and what areas the overlap was in. They cited counselling, assessment, education and the providing of support to both children and their parents.

All team members feel that such role overlapping generally has more positive effects for the team and for their patients but the members also identified some negative effects of this overlapping. Table 18 details these points.



TABLE 13

## PRIMARY ROLES OF TEAM MEMBERS

Discipline	Perceptions of own Role	Perceptions of Role by Others
Audiologist	<ul style="list-style-type: none"> <li>-audiological assessment</li> <li>-external referrals</li> <li>-education of parents and kids</li> </ul>	<ul style="list-style-type: none"> <li>-general agreement about audiological assessment</li> <li>-but also see role as teaching, follow-up and contributing to total assessment of child</li> </ul>
Speech Therapist	<ul style="list-style-type: none"> <li>-assessment of speech and language disorders, and provide therapy for same</li> </ul>	<ul style="list-style-type: none"> <li>-general agreement about speech and language disorder assessment but also see role as teaching and counselling of parents</li> </ul>
Psychologists	<ul style="list-style-type: none"> <li>-assessment of child and parent-child relationships</li> <li>-provide counselling and therapy for child with developmental, emotional, behavioral disorders</li> <li>-provide parenting counselling</li> <li>-assess child for school placement</li> </ul>	<ul style="list-style-type: none"> <li>-general agreement on assessment and therapeutic role but also see a large community outreach role via school contacts, public speaking assignments</li> </ul>
Physicians	<ul style="list-style-type: none"> <li>-developmental assessment and diagnosis</li> <li>-teaching of students in various disciplines</li> <li>-co-ordinate and plan on-going patient care in clinic</li> </ul>	<ul style="list-style-type: none"> <li>-general agreement on developmental assessment and diagnostic role. Most recognize co-ordinative role and see the physicians as consultants and case "overseers".</li> </ul>
Social Workers	<ul style="list-style-type: none"> <li>-teaching, counselling and supporting parents of children with developmental behavior or emotional disorders.</li> <li>-provide parenting groups</li> </ul>	<ul style="list-style-type: none"> <li>-general agreement on supportive, and counselling and educative role with parents. See role as primarily working with parents as opposed to children.</li> </ul>
Nursery School	<ul style="list-style-type: none"> <li>-observation of children and their relationships with peers and with parents</li> <li>-act as liaison with other team members on shared cases</li> <li>-counsel parents</li> </ul>	<ul style="list-style-type: none"> <li>General agreement on observation and assessment role. Also agree that role is to teach and model child management to parents. Also see the role as stimulating development and forming relationships with children with various disorders.</li> </ul>

TABLE 14  
ROLE NEGOTIABILITY

Role Negotiability	Frequency of Response	Percentage of Response
Negotiable	9	75
Non Negotiable	3	25
Total	12	100

TABLE 15  
ROLE NEGOTIATION

Discipline	Personnel Involved in Role Renegotiation
Audiologist	answer not useable
Speech Therapists	Dept. Head, Director of C.D.C., other Speech Therapist
Psychologists	Director of C.D.C. but not other psychologist
Physicians:	U. of M. Medical Faculty and Health Sciences Administration
1. )	
2. )	
3.	Director of C.D.C. only
Social Workers	Team Physicians, Dept. Head, other social worker
Nursery School Teachers	Director of C.D.C., Dr. Loadman - other teacher

TABLE 16  
OCCURRENCE OF ROLE OVERLAP

Degree of Role Overlap	Frequency of Response	Percentage of Response
A Great Deal	8	66.7
Somewhat	4	33.3
Not Sure	-	-
Hardly At All	-	-
Not At All	-	-
Total	12	100.0

TABLE 17  
OVERLAPPING ROLES

Discipline	Role Overlap With					Social Work	NS T
	Audiologists	Speech Therapists	Psychologists	Phys.	Work		
Audiologists	-	✓*	✓	✓	-	-	
Speech Therapist	✓	✓	✓	✓	✓	-	
Psychologists	✓	✓	✓	✓	✓	✓	
Physicians	✓	✓	✓	✓	✓	✓	
Social Workers	✓	✓	✓	✓	✓	✓	
Nursery School Teachers	✓	✓	✓	✓	✓	✓	

\*✓ mention made of role overlap by at least one member of the discipline

TABLE 18  
CONSEQUENCES OF ROLE OVERLAP

Positive	Negative
-provides support for team members	-follow-up may get missed
-shows blurred role lines can be effective	-goals and purpose with each case may not be clear and commonly shared
-provides comprehensive patient care	-only helpful if all team members know/appreciate skills of other team members
-helps put patient's needs in perspective	
-helps prioritize patient needs	
-prevents professionals from developing rigid view of own discipline	
-provides flexibility of service to suit patient needs	
-takes advantage of all professional's skills	

Table 19 indicates that most team members feel that they could be doing more to improve the quality or quantity of the work they are presently doing. The psychologists, social workers and the speech therapists note the need for improvements in the present working relationships between members of ie. improved co-ordination in follow-up, more role overlap, less client territorialism by age, and the development of program evaluation.

TABLE 19

SUGGESTIONS FOR INCREASED SERVICES OR INVOLVEMENTS  
BY TEAM MEMBERS

Discipline	Suggestions* For More Services or Involvement
Audiologist	-need more staff before could offer more and varied services
Speech Therapists	-more involvement with Social Work to co-ordinate patient care on shared cases
Psychologists	<ul style="list-style-type: none"> <li>-increase direct intake assessment role</li> <li>-increase involvement with children ages 2 - 4 yrs.</li> <li>-more research and evaluation re: programming</li> <li>-increase quality/efficiency of follow-up</li> </ul>
Physicians	-can do <u>no</u> more with staffing, case load and service commitments situation
Social Workers	<ul style="list-style-type: none"> <li>-more group work re: parenting and personal growth</li> <li>-more role overlap with other disciplines and less parent/child territorialism</li> </ul>
Nursery School Teachers	-can do <u>no</u> more with staffing, case load and service commitments situation

\* From own and other team disciplines

## 2. Communication

### (a) Record Keeping

Table 20 indicates that the C.D.C. team keeps common team records. All members contribute test results, treatment recommendations and letters to referral sources to these records.

TABLE 20

OCCURRENCE OF AND CONTRIBUTIONS TO COMMON TEAM RECORDS

Are Common Records Kept?	Frequency of Response	Percentage of Response
Yes	12	100
No	-	-
Total	12	100
Do you contribute to them?		
Yes	12	100
No	-	-
Total	12	100

Table 21 indicates that 50% of the team members also keep private files which they usually share with team members also involved with the case. These files generally serve as personal reminders of the therapists involvement with the case. Noticeably absent from all files are regular process recordings, goals of treatment, formal case intake, referral or follow-up forms, and social histories.

TABLE 21  
PRIVATE FILES KEPT AND SHARED  
AS RECORDED BY FREQUENCY OF RESPONSE

Discipline	n	Private Files				
		Kept		Shared		Not Applicable
		Yes	No	Yes	No	
Audiologist	1	1	-	-	1	-
Speech Therapists	2	1	1	-	1	1
Psychologists	2	-	2	-	-	2
Physicians	3	-	3	-	-	3
Social Workers	2	2	-	2	-	-
Nursery School Teachers	2	2	-	2	-	-
Total	12	6 (50%)	6 (50%)	4 (33.3%)	2 (16.7%)	6 (50%)

(b) Staff Meetings, Case Conferences, Rounds, etc.

Table 22 indicates that staff meetings are held by this team. (It is important to note that members defined the term "staff meetings" differently ie. some included all meetings held, in this definition while others only included those meetings held which dealt with intermember problems. This accounts for the split in responses.)

TABLE 22  
OCCURRENCE OF STAFF MEETINGS

Staff Meetings Held	Frequency of Response	Percentage of Response
Yes	10	83.3
No	2	16.7
Total	12	100.0

Table 23 identifies the number and variety of meetings held by this team. It is noted that no meeting is held for the specific purpose of dealing with intermember difficulties that arise on the team. It is also noted that the physicians attend all meetings but that no forum for case conferences involving the total membership exists. The speech therapists and the audiologist are not involved in any "case rounds", even with the physicians. The physicians are the only team members who attend meetings involving policy and procedure issues.

TABLE 23

MEETINGS HELD, THEIR PARTICIPANTS, THEIR  
FUNCTION AND THE FREQUENCY OF OCCURRENCE

Type of Meeting	Invited * Participants	Function	Frequency
General Rounds	-all team members (each member presents on rotation basis)	-info. sharing	-every week
Nursery School Rounds	-physicians, teachers, psychology*, social work*	-case review both active and on waiting list -referral discussion	-every 2 weeks
Social Work Rounds	-physicians, social workers	-case planning review -referral discussion	-irregular but should be every 2 weeks
Luncheon Meeting	-all team members	-social get together (original intent was to discuss team issues, intermember relationships, etc.)	-once a month
Pediatric Rounds	Team Physicians	-discuss admini- strative issues ie. policy, procedures, etc.	-once a month

\* do not always attend



Table 24 indicates that 66.7% of team members would like more meetings held. The physicians however see no need for more meetings. Table 25 indicates that one of these meetings would be for the purpose of case conferences, case reviews and case presentations, and the other would be for discussing inter-staff difficulties, policy and procedures issues and program changes.

TABLE 24

## TEAM MEMBER'S DESIRE FOR MORE TEAM MEETINGS

Desire More Meetings	Frequency of Response	Percentage of Response
Yes	8	66.7
No	4	33.3
Total	12	100.0

TABLE 25

## PURPOSE OF PROPOSED MEETINGS

Purpose of Additional Meetings	Frequency of Response/Total wanting More Meetings	Percentage of Response
Case conferences (co-ordinate case review and planning; review referrals, share case presentations)	6 / 8	75
Staff Meetings (discuss team policy and procedures; inter team conflicts; (new and old) offered by team members; changes in HS affecting C.D.C.)	5 / 8	62.5

The communication pattern on this team is described as horizontal by 58.3% of the team members and also as informal by 91.6% of the members (see Table 26). It is considered to be "somewhat" to "very effective" (see Table 27) by 83.3% of the members although team members identified some difficulties with the system as it is. Common record keeping is generally felt to be a valuable concept but in practice results in problems of pursuing one file from worker to worker. The ultimate result being sporadic and infrequent contributions being made to the file. The informal pattern of consultation appeals to the team members yet they describe it as "catch-as-catch-can". The result is unilateral decision-making, missed follow-up, lengthy case involvement rather than timely referral or case termination, and narrow rather than comprehensive conceptions of casework and client's needs. These difficulties are also blamed for intermember conflicts and frustrations.

The team members suggest that regularly scheduled and structured case conferences and more formalized record keeping, case reviews and referral procedures could help to solve these problems.

TABLE 26

## TEAM COMMUNICATION PATTERNS

COMMUNICATION PATTERNS					
Vertical	Horizontal	Other	Formal	Informal	Other
2 (16.7%)	7 (58.3%)	3 (25%)	-	11 (91.6%)	1 (8.3%)
	12			12	Total

Frequency  
of Response

TABLE 27

EFFECTIVENESS OF THE TEAM'S COMMUNICATION PATTERN  
AS RECORDED BY FREQUENCY AND PERCENTAGE OF RESPONSE

Discipline	n	Degree of Effectiveness				
		Very Effective	Somewhat Effective	Not Sure	Somewhat Ineffective	Very Ineffective
Audiologist	1	-	1	-	-	-
Speech Therapists	2	-	1	1	-	-
Psychologists	2	-	2	-	-	-
Physicians	3	3	-	-	-	-
Social Workers	2	-	1	-	1	-
Nursery School Teachers	2	1	1	-	-	-
Total	12	4 (33.3%)	6 (50%)	1 (8.3%)	1 (8.3%)	-

### 3. PROBLEM SOLVING AND DECISION MAKING

Table 28 indicates that 91.7% of the team members feel that the team leader, often in conjunction with other team members, makes policy and procedure decisions. 91.7% of the members feel that the primary therapists on each case are the decision-makers with regards to treatment choice. 83.3% of the members feel that decisions about case termination and referral are shared by the primary therapist and the other team members involved with each case. Case assignment decisions are perceived by 50% of the members as being made by any one of the team physicians.

TABLE 28

PRIMARY TEAM DECISION-MAKER(S)  
AS RECORDED BY FREQUENCY AND PERCENTAGE OF RESPONSE

Primary Decision Maker	Decision Areas			
	Policy	Treatment Choice	Case Termination/Referral	Case Assignment
Director/Team Leader	6 (50)*	-	-	-
Primary Therapist on each case	-	11 (91.7)	-	-
Primary Therapist with other relevant team members	-	-	10 (83.3)	-
Secretaries	-	-	-	2 (16.7)
All team members together - Director holding last say	5 (41.7)	-	-	-
Any/All Physicians	1 (8.3)	-	-	6 (50)
Primary Therapist and case physician	-	1 (8.3)	2 (16.7)	-
Team or external Referral Source	-	-	-	4 (33.3)
Total	12	12	12	12

\* percentage

100% of team members feel that they have some, to a lot, of influence in overall decision-making on the team (see Table 29) especially in the area of patient care and organizing their own work schedules (see Table 30). They feel that they have little influence into policy and procedure issues.

TABLE 29

DEGREE OF MEMBER INFLUENCE INTO DECISION-MAKING  
AS RECORDED BY FREQUENCY OF RESPONSE

Discipline	n	Degree of Influence				
		A Lot	Some	Not Sure	Little	None
Audiologist	1	1	-	-	-	-
Speech Therapists	2	-	2	-	-	-
Psychologists	2	-	2	-	-	-
Physicians	3	2	1	-	-	-
Social Workers	2	-	2	-	-	-
Nursery School Teachers	2	2	-	-	-	-
Total	12	5(41.7%)	7(58.3%)	-	-	-

TABLE 30

AREAS OF MEMBER INFLUENCE/NO INFLUENCE ON THE TEAM

Disciplines	Have Influence	Have No Influence
Audiologist	-patient care and work schedule	-decisions which affect other team members and not me
Speech Therapists	-patient care and work schedule	-policy, team management and administration
Psychologists	-patient care and work schedule -hiring new staff	-policy, team management and administration
Physicians	-all areas	-no areas unless by choice
Social Workers	-patient care and work schedule -staff problems	-political administrative issues involving C.D.C. and Health Sciences
Nursery School Teachers	-patient care	-decisions which affect other team members and not me

Table 31 indicates that 91.7% of the members are quite, to very satisfied with the amount of influence they are allowed although they do suggest methods for improving the decision-making process on the team. The delegation and sharing of administrative decision-making was the most frequently mentioned suggestion by team members, including the team leader. The speech therapists suggested that the appointment of a senior person in each discipline represented on the team would increase member participation in administrative decision-making.

TABLE 31

MEMBER'S SATISFACTION WITH DEGREE OF INFLUENCE THEY ARE ALLOWED AS RECORDED BY FREQUENCY OF RESPONSE

Discipline	n	Degree of Satisfaction				
		Very Satisfied	Quite Satisfied	Not Sure	Quite Dissatisfied	Very Dissatisfied
Audiologist	1	-	1	-	-	-
Speech Therapists	2	1	1	-	-	-
Psychologists	2	-	2	-	-	-
Physicians	3	3	-	-	-	-
Social Workers	2	1	-	-	1	-
Nursery School Teachers	2	-	2	-	-	-
Total	12	5 (41.7%)	6 (50%)	-	1 (8.3%)	-

Table 32 indicates that 50% of the team members feel that the usual pattern of decision-making on this team is by consensus, although the other 50% of the team members do not agree on any one common pattern.

The team leader is perceived by 66% of the team members as strongly encouraging intermember consultations (see Table 33). The usual patterns of consultation are outlined on Table 34 and are diagrammatically presented in Figure 2.

TABLE 32

THE TEAMS' DECISION-MAKING PATTERN AS RECORDED  
BY FREQUENCY OF RESPONSE

Discipline	n	Decision-Making Pattern				
		Majority Rules	Minority Rules	Consensus	Authority Rules	Silent Consent
Audiologists	1	1	-	-	-	-
Speech Therapists	2	-	1	1	-	-
Psychologists	2	-	-	2	-	-
Physicians	3	-	-	2	-	1
Social Workers	2	1	-	1	-	-
Nursery School Teachers	2	1	-	-	1	-
Total	12	3(25%)	1(8.3%)	6(50%)	1(8.3%)	1(8.3%)

TABLE 33

DEGREE TO WHICH THE TEAM LEADER ENCOURAGES INTERMEMBER  
CONSULTATION AS RECORDED BY FREQUENCY OF RESPONSE

Discipline	n	Degree of Encouragement				
		Strongly Encourages	Encourages Somewhat	Not Sure	Discourages Somewhat	Strongly Discourages
Audiologist	1	1	-	-	-	-
Speech Therapists	2	1	-	1	-	-
Psychologists	2	1	1	-	-	-
Physicians	3	3	-	-	-	-
Social Workers	2	1	1	-	-	-
Nursery School Teachers	2	1	1	-	-	-
Total	12	8(66.7%)	3(25%)	1(8.3%)	-	-

TABLE 34

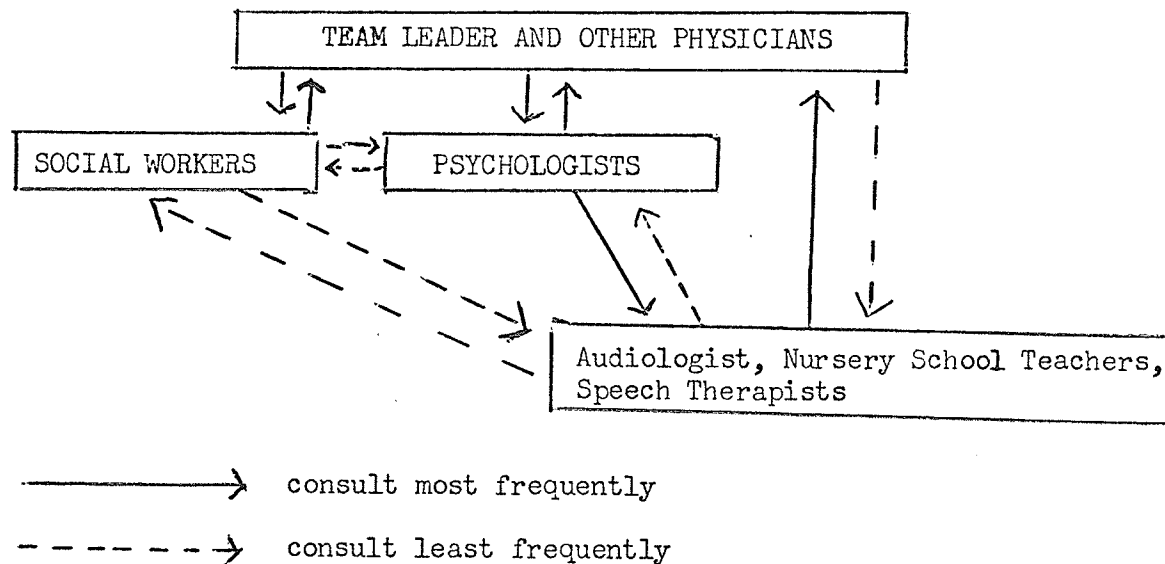
CONSULTATION PATTERNS ON THE TEAM AS RECORDED BY  
DISCIPLINE AND OCCURRENCE OF CONSULTATION

Discipline	Intermember Consultations					
	Speech				Social NS	
	Audiologist	Therapist	Psychologist	Physicians	Worker	T
Audiologist	-	✓*	X	✓	X	X
Speech Therapist	✓	✓	X	✓	X	X
Psychologists	✓	✓	✓	✓	X	✓
Physicians	X	X	✓	✓	✓	X
Social Workers	X	X	X	✓	✓	X
Nursery School Teachers	X	X	X	✓	X	X

✓\* consult with most frequently

X consult with least frequently

FIGURE 2: CONSULTATION PATTERN ON TEAM





The leader and the other physicians consult most frequently with the social workers and the psychologists. Consultations between other core members occur less frequently as they function relatively independently, the psychologists being more independent from the physicians than the social workers. The audiologist, speech therapist and nursery school teachers consult most frequently with each other and with the physicians.

Table 35 shows that intermember consultations are considered to be very helpful by 83.3% of the team members.

TABLE 35

HELPFULNESS OF INTERMEMBER CONSULTATION AS RECORDED  
BY FREQUENCY OF RESPONSE

Discipline	n	Degree of Helpfulness				
		Very Helpful	Somewhat Helpful	Not Sure	Somewhat Unhelpful	Very Unhelpful
Audiologists	1	-	1	-	-	-
Speech Therapists	2	1	1	-	-	-
Psychologists	2	2	-	-	-	-
Physicians	3	3	-	-	-	-
Social Workers	2	2	-	-	-	-
Nursery School Teachers	2	2	-	-	-	-
Total	12	10 (83.3%)	2 (16.7%)	-	-	-

The team generally feels that their clients are aware that C.D.C. uses a team approach to service delivery (see Table 36). Some clients, especially those who are experiencing custody and access difficulties, are advised of the C.D.C.'s team practice. Other clients become aware of the team practice when they are seen by more than one team member. Table 37 indicates that the team practice is perceived as enhancing the client's satisfaction with the service they receive from C.D.C.

TABLE 36

TEAM MEMBER'S PERCEPTIONS OF PATIENT'S AWARENESS  
OF C.D.C.'S TEAM APPROACH

Patients Aware of Team Approach	Frequency of Response	Percentage of Response
Yes *	7	58.3
No	5	41.7
Total	12	100.0

\* if seen by more than one team member

TABLE 37

TEAM MEMBER'S PERCEPTIONS OF THE EFFECTS OF TEAM  
PRACTICE ON CLIENTS' SATISFACTION WITH SERVICE

Effects of Team Practice	Frequency of Response	Percentage of Response
Contributes to patient satisfaction	9	75
Doesn't contribute to patient satisfaction	2	16.7
Don't know	1	8.3
Total	12	100.0

#### 4. Task Assignment

Case assignment is usually managed by the team physicians who assess patient's needs on a basis of a written referral from a community source. Cases are then assigned to appropriate team disciplines whose secretaries assign the cases to the team member with the earliest available appointment. For example, a school placement problem is usually referred to the psychologists, a child abuse case to the social workers

and so on. Some cases are referred to specific team members by external resources. These referrals are assigned as requested. No formal internal referral and case assignment procedure exists but it is the primary therapist's (the first person to see the case) role, to involve whatever team members he sees a need for. (Note: These responses did not lend themselves to tabular representation.)

Table 38 indicates what types of case each team member usually sees. The physicians are involved in all types of cases while the cases seen by other team members are more limited. Generally, while there is overlapping of cases across disciplines, the psychologists, nursery school teachers, audiologist and speech therapists deal with children while the social workers work with their parents. The audiologist and speech therapists are involved in speech, language and hearing problems while other disciplines are involved with a broader range of presenting problems.

Table 39 indicates that most team members feel that there are areas in which they could extend their service efforts. It is noted that the audiologist and speech therapists would like to do more work separate from C.D.C. Other disciplines who would like to work outside of C.D.C. would like to do so as an extension of their team efforts.

100% of team members feel that their treatment suggestions and plans are always or sometimes followed. They note that there is always mutual discussion and agreement before plans are changed (see Table 40).

TABLE 38  
 TYPES OF CASES SEEN BY TEAM MEMBERS

Discipline	Types of Cases Seen *						
	Behavior Problems	Communication Problems	Development Problems	School Problems	Custody Problems	Adoption/foster problems	Other
Audiologist	-	✓	-	-	-	-	-
Speech Therapists	-	✓	✓	-	-	-	-
Psychologists	✓	✓	✓	✓	✓	✓	-
Physicians	✓	✓	✓	✓	✓	✓	✓
Social Workers	✓	-	✓	-	✓	-	✓
Nursery School Teachers	✓	✓	✓	✓	✓	-	✓

✓ involvement with cases

\* children and their parents

TABLE 39  
CASES EACH MEMBER FEELS HE SHOULD SEE

Discipline	Cases should be seeing
Audiologist	more in-patient service in H.S. Complex
Speech Therapists	more work with children and their parents in the home/school/community
Psychologist	younger children (2-4 yrs.) for assessment
Physicians	more developmental assessments of all children in government care
Social Workers	Supportive, educational, counselling with families of newly diagnosed mentally retarded children -supportive and educational counselling for families with children with communication disorders
Nursery School Teachers	-no more

TABLE 40

EXTENT TO WHICH MEMBER'S TREATMENT PLANS/SUGGESTIONS  
ARE FOLLOWED AS RECORDED BY FREQUENCY

Discipline	n	Degree to Which Treatment Suggestions Followed				
		Always followed	Sometimes* followed	Not Sure	Sometimes Rejected/ Ignored	Always Rejected/ Ignored
Audiologist	1	-	1	-	-	-
Speech Therapists	2	2	-	-	-	-
Psychologists	2	-	2	-	-	-
Physicians	3	1	2	-	-	-
Social Workers	2	1	1	-	-	-
Nursery School Teachers	2	-	2	-	-	-
Total	12	4 (33.3%)	8 (66.7%)	-	-	-

\* all respondents noted that discussion always occurred prior to changes in plans being implemented

## 5. TEAM PURPOSE

The team member's responses to the question "what is the team's purpose?" differed only in their precise wordings. A summation of the various descriptions of the team's purpose could be represented as: "To provide comprehensive care (supportive, educational and therapeutic) to children and their families with developmental, emotional or behavioral problems and to assist in the carry-over of that care into the community."

Table 41 indicates each team member's purpose as described by each. All team members feel that their personal and the team purposes compliment one another, even though, as Table 42 indicates, the team purpose is assumed and not formally documented.

TABLE 41

TEAM MEMBER'S PURPOSES AS RECORDED BY DISCIPLINE

Discipline	Purpose
Audiologist	same as role description*
Speech Therapists	early detection, remediation and counselling re: speech/language problems
Psychologists	provide for psychological well being of children and their families
Physicians	same as clinic's purpose
Social Workers	same as role description*
Nursery School Teachers	provide programs geared to children's needs and to counsel and support parents

\* refer to Table 30

TABLE 42

## TEAM'S PURPOSE - FORMAL OR ASSUMED

Team Purpose	Frequency of Response	Percentage of Response
Formal	1	8.3
Assumed	10	83.4
Not Sure	1	8.3
Total	12	100.0

The team's focus re: patient care as perceived by 100% of its members, is to provide a combination of psychological, social and physical care to its patients. Only those team members actually involved in providing physical care, the audiologist, speech therapists and physicians, cite this aspect of the team's focus while all members note the emphasis on psychological and social care (see Table 43).

TABLE 43

TEAM'S FOCUS RE:  
PATIENT CARE AS RECORDED BY FREQUENCY AND PERCENT

Discipline	n	Focus re: Patient Care				
		(a) Physical	(b) Psychological	(c) Social	Other	
					A&B&C	B&C
Audiologist	1	-	-	-	1	-
Speech Therapists	2	-	-	-	2	-
Psychologists	2	-	-	-	-	2
Physicians	3	-	-	-	3	-
Social Workers	2	-	-	-	-	2
Nursery School Teachers	2	-	-	-	-	2
Total	12	-	-	-	6 (50%)	6 (50%)

## 6. CONFLICT

Table 44 indicates that 100% of the team members feel that there is some conflict on this team. Conflict is felt to occur primarily as a result of personality clashes (see Table 45). It is noted that one nursery school teacher and one speech therapist feel that conflict arises out of communication breakdowns. The other nursery school teacher feels conflict is a result of a lack of trust on the team. The audiologist and a social worker see the conflict as arising out of ideological differences about patient care.

TABLE 44

OCCURRENCE OF CONFLICT ON THE TEAM AS RECORDED  
BY FREQUENCY AND PERCENT

Discipline	n	Degree of Conflict on Team				
		Great Deal	Some	Not Sure	Little	None
Audiologist	1	-	1	-	-	-
Speech Therapists	2	-	1	1	-	-
Psychologists	2	-	2	-	-	-
Physicians	3	-	2	-	1	-
Social Workers	2	-	2	-	-	-
Nursery School Teachers	2	-	1	1	-	-
Total	12	-	9(75%)	2 (16.7%)	1 (8.3%)	-



TABLE 45

CONFLICT ISSUES ON THE TEAM AS RECORDED  
BY FREQUENCY AND PERCENT OF RESPONSE

Discipline	n	Sources of Team Conflict				
		Personality Clashes	Communication Breakdowns	Lack of Trust	Ideological issues re: Patient Care	Not Sure
Audiologist	1				1	
Speech Therapists	2		1			1
Psychologists	2	2				
Physicians	3	3				
Social Workers	2	1			1	
Nursery School Teachers	2		1	1		
Total	12	6 (50%)	2 (16.7%)	1 (8.3%)	2 (16.7%)	1 (8.3%)

Table 46 indicates that 91.7% of team members feel that the team views conflict on the team as detrimental. 58.3% noted that conflict is usually ignored unless it becomes so disruptive that it must be confronted although it is not necessarily resolved even then.

Table 47 shows that the team's climate is not perceived the same by all team members. Three team members (25%), a speech therapist, the team leader and one other physician, see the climate as being totally positive while all other team members (75%) note either some negative elements or a totally negative climate on the team. This disparity of views exists within and across disciplines. In spite of this, Table 48 indicates that 83.4% of team members feel quite satisfied with the team's climate.

TABLE 46

TEAM MEMBER'S PERCEPTIONS OF CONFLICT MANAGEMENT  
ON THE TEAM AS RECORDED BY FREQUENCY AND PERCENT

Discipline	n	Conflict Is			
		Valued	Detrimental	Ignored	Confronted*
Audiologist	1	-	1	1	-
Speech Therapists	2	-	2	1	1
Psychologists	2	-	2	2	-
Physicians	3		3		3
Social Workers	2	1	1	2	
Nursery School Teachers	2		2	1	1
Total	12	1 (8.3%)	11 (91.7%)	7 (58.3%)	5 (41.7%)

\* not necessarily resolved

TABLE 47

## THE TEAM'S CLIMATE AS RECORDED BY FREQUENCY

Discipline	n	CLIMATE												
		(A)	(B)	(C)	(D)	(E)	(F)		Other					
		Open & Respectful	Anxiety	Frustration	Discontent	General Satisfaction	Pavania & Distrust	C & E	D & F	E & F				
Audiologist	1	-	-	-	-	-	-	-	-	-	-	-	-	-
Speech Therapists	2	1	-	1	-	-	-	-	-	-	-	-	-	-
Psychologists	2	-	-	1	-	-	-	-	-	1	-	-	-	-
Physicians	3	1	-	1	-	1	-	-	-	-	-	-	-	-
Social Workers	2	-	-	-	-	-	-	-	-	-	-	-	1	1
Nursery School Teachers	2	-	-	-	-	-	-	-	-	1	-	-	1	-
Total	12	2 (16.7%)	-	3 (25%)	-	1 (8.3%)	-	1 (8.3%)	1 (8.3%)	1 (8.3%)	1 (8.3%)	2 (16.7%)	1 (8.3%)	1 (8.3%)

TABLE 48  
TEAM MEMBER'S SATISFACTION WITH TEAM'S CLIMATE

Degree of Satisfaction	Frequency of Response	Percentage of Response
Very Satisfied	-	-
Quite Satisfied	10	83.4
Not Sure	1	8.3
Quite Dissatisfied	1	8.3
Very Dissatisfied	-	-
Total	12	100.0

Table 49 indicates that 83.3% of team members feel that conflict could be better managed by the open confrontation of conflict issues by the team leader and all the team members at regularly scheduled staff meetings.

TABLE 49  
TEAM MEMBER'S SUGGESTIONS FOR IMPROVED CONFLICT MANAGEMENT

Suggestions for Conflict Management	Frequency of Response	Percentage of Response
-individual meetings between each discipline and team leader	4	33.3
-open confrontation of conflict issues by leader and all team members at regular monthly staff meetings	6	50.0
-can't be improved as personalities are cause of conflict	2	16.7
Total	12	100.0

## 7. ENVIRONMENT

Table 50 indicates that some team member's direct supervisors are outside of C.D.C. while other members are supervised by the C.D.C. Director. The social workers, audiologist and speech therapists are responsible to their respective department heads in the Health Sciences complex. The physicians share a collegial relationship with one another but are technically employed by the U of M and are under the Head of Medicine in the Health Sciences Complex. Only the psychologists and the nursery school teachers are responsible solely to the Director of C.D.C. Table 51 indicates that those team members who share allegiance to the H.S.C. also have service responsibilities there.

TABLE 50  
TEAM MEMBER'S DIRECT SUPERVISORS

<u>Discipline</u>	<u>Direct Supervisor</u>
Audiologist	Director of Dept. of Communication Disorders, Health Sciences
Speech Therapists	Director of Dept. of Communication Disorders, Health Sciences
Psychology	Director of C.D.C.
Physicians	under contract to U of M and Health Sciences but have collegial relationship with Director at C.D.C.
Social Workers	Director of Dept. of Social Work, Health Sciences
Nursery School Teachers	Director of C.D.C.

TABLE 51

## TEAM MEMBER'S RESPONSIBILITIES OUTSIDE OF C.D.C.

Discipline	External Responsibilities				
	H.S. Boards & Committees	H.S. Paperwork	H.S. Teaching	H.S. Service Delivery	None
Audiologist	-	-	✓	✓	-
Speech Therapists	-	-	✓	-	-
Psychologists	-	-	-	-	✓
Physicians	✓	-	✓	✓	-
Social Workers	✓	✓	✓	-	-
Nursery School Teachers	-	-	-	-	✓

TABLE 52

## TEAM MEMBER'S AWARENESS OF C.D.C.'S ASSOCIATION WITH (THE HEALTH SCIENCE COMPLEX) ITS HOST ORGANIZATION AS RECORDED BY FREQUENCY AND PERCENT OF RESPONSE

Discipline	n	Degree of Awareness				
		Very Aware	Somewhat Aware	Not Sure	Somewhat Unaware	Very Unaware
Audiologist	1	-	1	-	-	-
Speech Therapists	2	1	1	-	-	-
Psychologists	2	-	-	-	1	1
Physicians	2	2	-	-	-	1
Social Workers	2	1	-	-	-	1
Nursery School Teachers	2	1	-	-	1	-
Total	12	5(41.7%)	2(16.7%)	-	2(16.7%)	3(25%)

Table 52 indicates that team members vary in their awareness of the C.D.C.'s relationship with the H.S.C. The audiologist, speech therapists, one social worker and one nursery school teacher are the most aware of this relationship. These members note some positive effects of this relationship, ie. personal satisfaction gained through working with other professionals in an organization with a broader health focus and, salaries are felt to be higher than they would be if C.D.C. was an independent organization. The negative effects of this relationship are cited as: team members are excluded from opportunities for professional development and for collegial support unless they have strong organizational (departmental) links to H.S.C.; service commitments too time consuming and demanding on those members with split allegiance; a feeling of anomie experienced by some members with split allegiance; supervisors in H.S. don't have an appreciation of the time and service commitments and responsibilities carried by team members. In spite of these complaints, all team members state that these problems are not serious enough to have required resolution to date. Nonetheless, they did have some suggestions for improving the working relationship between the team and the host organization:

- 1) make C.D.C. independent from H.S.C. thus eliminating difficulties arising out of split allegiances
- 2) increase staff numbers to cope with service demands
- 3) increase the team's emphasis on research and evaluation to help convince H.S. administration of the team's effectiveness and importance and thereby ultimately increasing the team's independence.

### C. Team Effectiveness Diagnostic Instrument

NOTE: The reader is reminded that this instrument was used as a validity check for the staff interview schedule and that the responses should be viewed in that context. The findings for each sub-section are presented in two forms, 1) a graph indicating the general perceptions of the team as a unit, and 2) a table presenting the specific responses to each question as recorded by discipline.

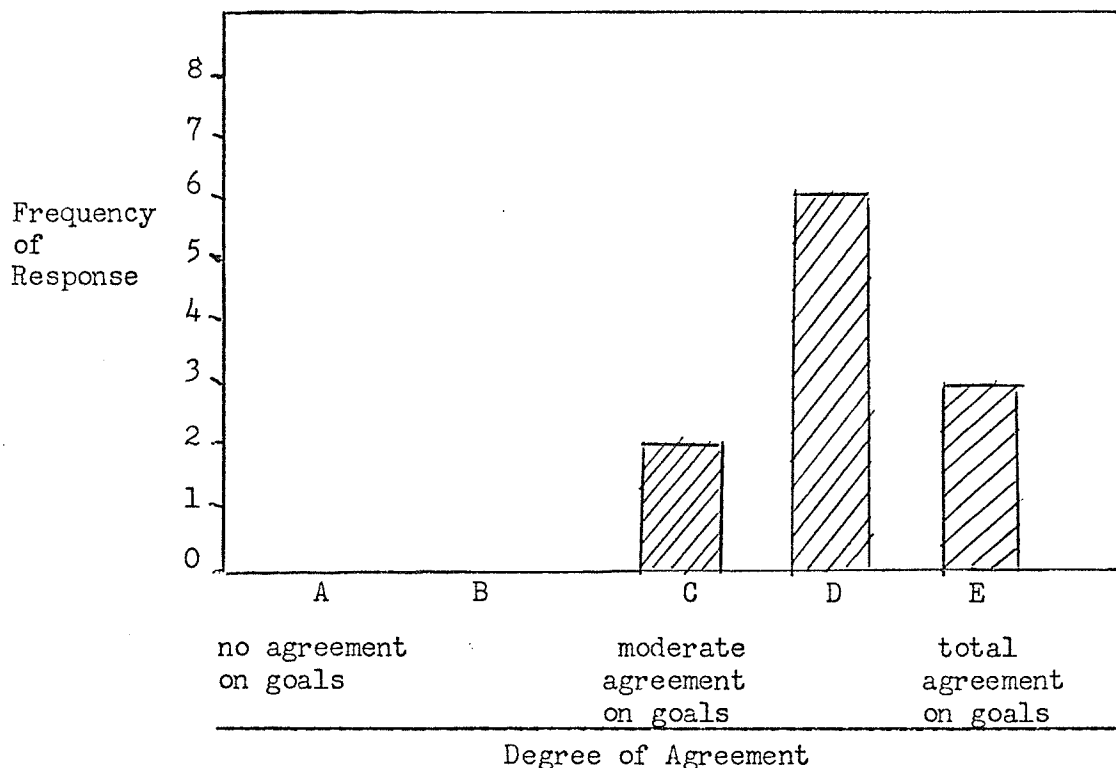
#### 1. Goal Agreement on the Team

Tables 53 and 54 indicate that 75% of the team members agree on the team's goal. This finding supports the findings presented previously in Table 43 wherein 100% of the members identified a common purpose.

Scale I

TABLE 53

TEAM MEMBER'S OVERALL PERCEPTIONS OF AGREEMENT  
ON TEAM GOALS





Scale I

TABLE 54

SPECIFIC TEAM MEMBERS PERCEPTIONS OF AGREEMENT  
ON TEAM GOALS

Discipline	n	Degree of Agreement on Goals				
		No Agreement		Moderate Agreement		Total Agreement
		A	B	C	D	E
Audiologist	1				1	
Speech Therapists	2*			1		
Psychologists	2				2	
Physicians	3					3
Social Workers	2			1	1	
Nursery School Therapists	2				2	
Total	12			2(16.7%)	6(50%)	3(25%)

\* answer not useable

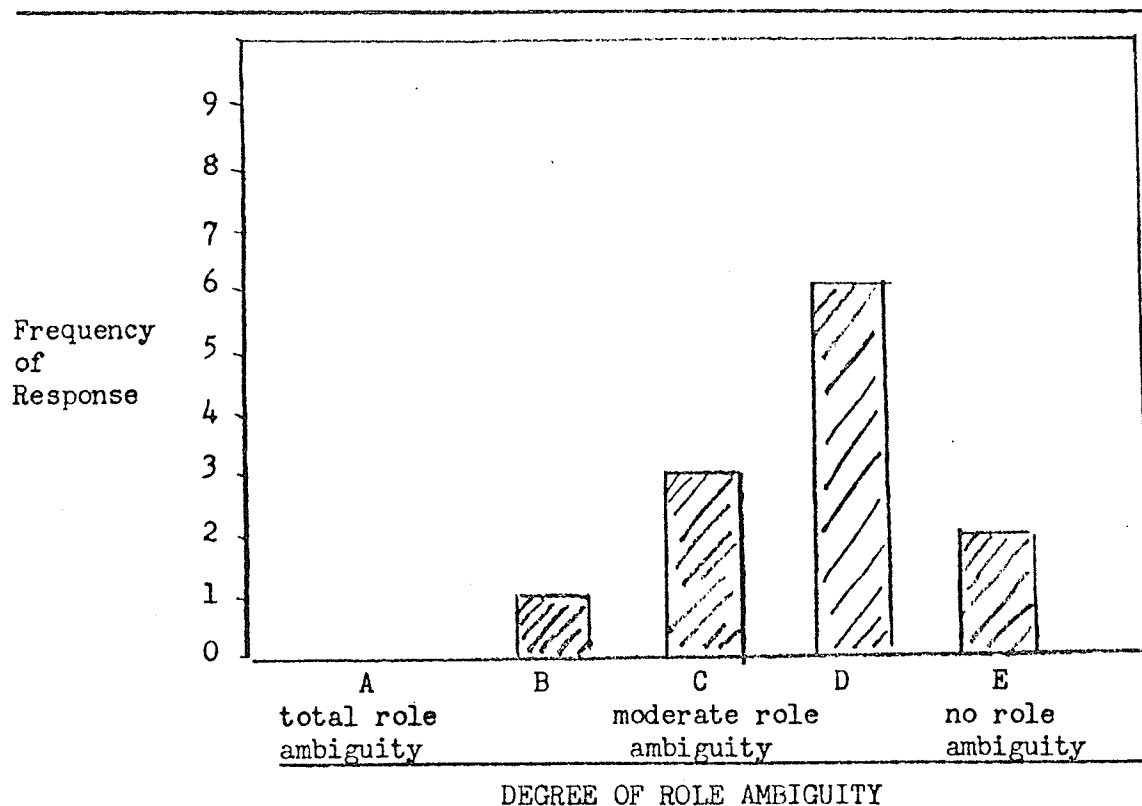
2. Role Ambiguity on the Team

66.7% of the team members feel that there is little to no role ambiguity on this team (see Table 55). This finding is congruent with Table 13 in the previous section. It is noted however, that some members (33.3%) do feel a moderate to great degree of role ambiguity on the team. They are the audiologist, one speech therapist, one nursery school teacher and one psychologist (see Table 56).

Scale II

TABLE 55

## TEAM MEMBER'S OVERALL PERCEPTIONS OF ROLE AMBIGUITY



Scale II

TABLE 56

## SPECIFIC TEAM MEMBER'S PERCEPTIONS OF ROLE AMBIGUITY RECORDED BY FREQUENCY

Discipline	n	Degree of Role Ambiguity				
		total role ambiguity		moderate role ambiguity		no role ambiguity
		A	B	C	D	E
Audiologist	1			1		
Speech Therapists	2			1	1	
Psychologists	2			1	1	
Physicians	3				2	1
Social Workers	2				1	1
Nursery School Teachers	2		1		1	
Total	12	-	1(8.3%)	3(25%)	6(50%)	2(16.7%)

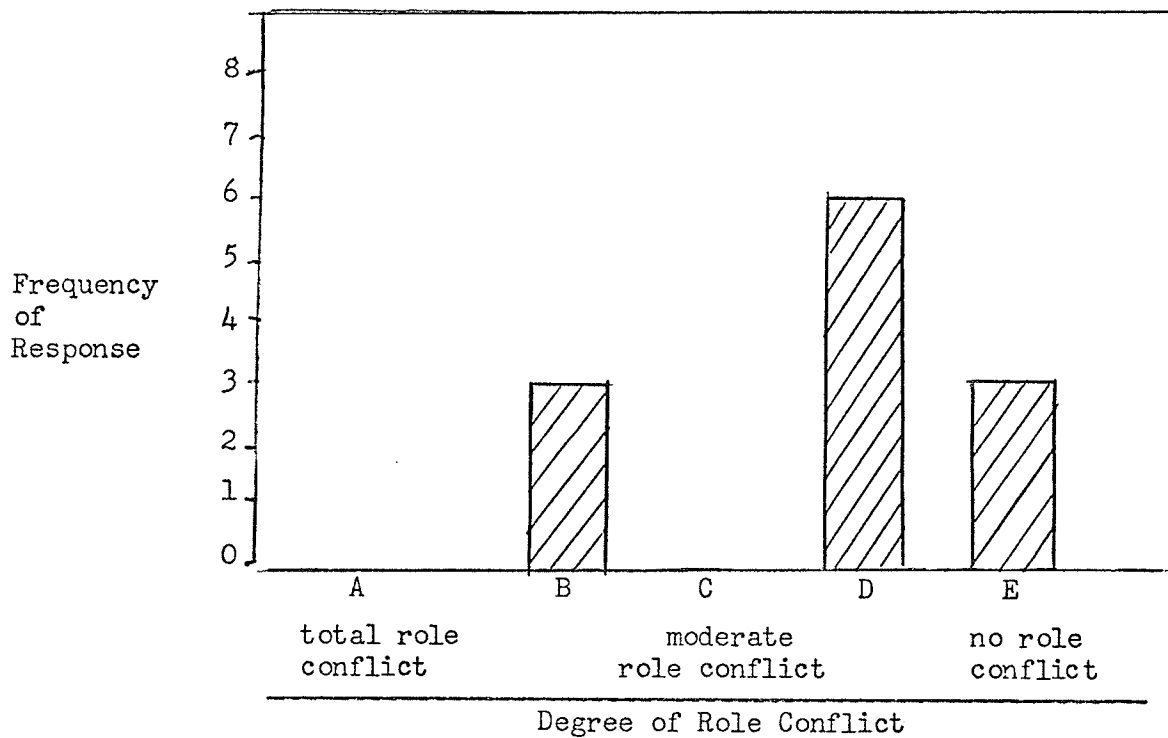
### 3. Role Conflict on the Team

Table 57 indicates that little to no role conflict is perceived on this team by 75% of the team members. This finding is also supportive of the findings presented in Table 13 which indicates strong agreement on this team between the real and perceived roles played by its members. However, it is noted that three team members (25%), the audiologist, one social worker and one nursery school teacher perceive a great deal of role conflict on the team (see Table 58).

Scale III

TABLE 57

TEAM MEMBER'S OVERALL PERCEPTIONS OF ROLE CONFLICT



Scale III

TABLE 58

## SPECIFIC TEAM MEMBER'S PERCEPTIONS OF ROLE CONFLICT

Discipline	n	Degree of Role Conflict				
		total role conflict A	B	moderate role conflict C	D	no role conflict E
Audiologist	1		1			
Speech Therapist	2				2	
Psychologists	2				1	1
Physicians	3				2	1
Social Workers	2		1			1
Nursery School Teachers	2		1		1	
Total	12		3 (25%)		6 (50%)	3 (25%)

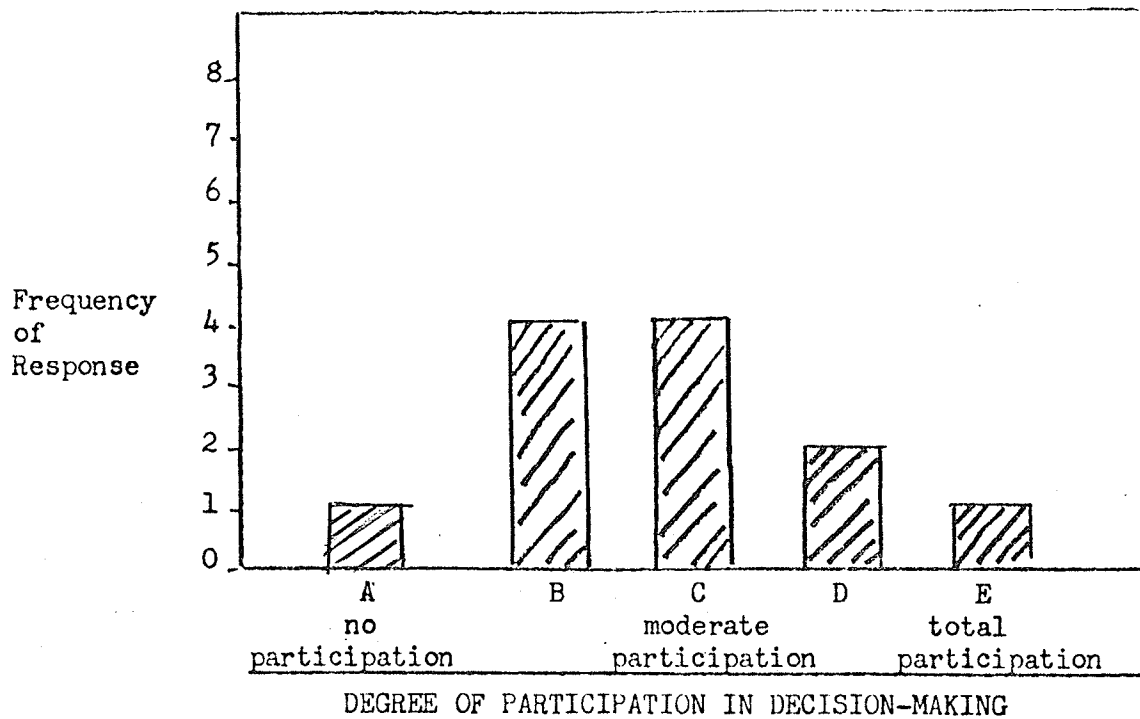
4. Decision-Making on the Team

Table 59 shows that 74.9% of the team members feel that there is moderate to no participation in decision-making on this team. This finding does not appear to be congruent with Table 29 which indicates that 100% of the team members perceive some to a great deal of influence in team decision-making. (see Table 60)

Scale IV

TABLE 59

TEAM MEMBER'S OVERALL PERCEPTIONS OF DEGREE  
OF MEMBER PARTICIPATION IN DECISION-MAKING



Scale IV

TABLE 60

SPECIFIC TEAM MEMBER'S PERCEPTIONS OF DEGREE OF  
MEMBER PARTICIPATION IN DECISION-MAKING

Discipline	n	Degree of Participation in Decision-Making				
		no participation		moderate participation		total participation
		A	B	C	D	E
Audiologist	1		1			
Speech Therapists	2			1	1	
Psychologists	2		1	1		
Physicians	3			1	1	1
Social Workers	2		2			
Nursery School Teachers	2	1		1		
Total	12	1 (8.3%)	4 (33.3%)	4 (33.3%)	2 (16.7%)	1 (8.3%)

### 5. Commitment to Team Decisions

75% of the team members feel that there is a great deal or a total commitment to the decisions made by the team (see Table 61). This finding would appear to support the findings presented in Table 31 which shows that 91.7% of the team members are satisfied with the degree of influence they have in team decision-making as satisfaction with team decisions precludes commitment to those decisions. It is noted however that one speech therapist, one psychologist and one nursery school teacher do not share this perception of high member commitment. (see Table 62)

Scale V

TABLE 61

TEAM MEMBER'S OVERALL PERCEPTIONS OF DEGREE OF  
COMMITMENT TO TEAM DECISIONS

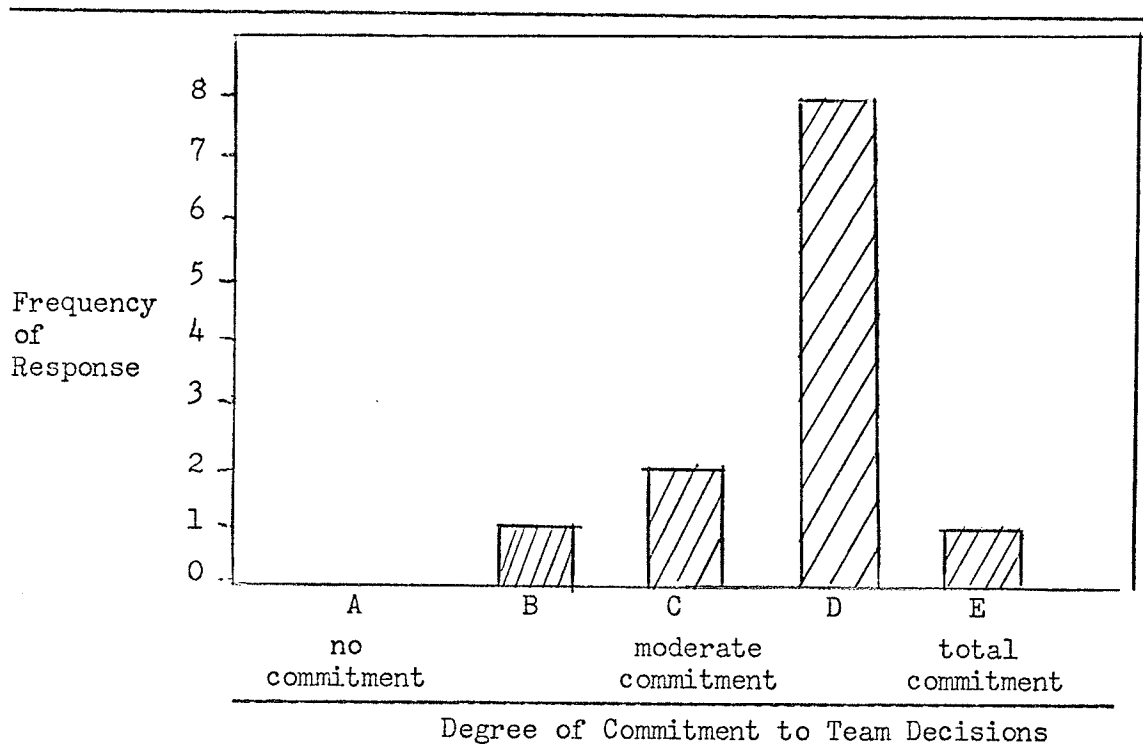


TABLE 62

SPECIFIC TEAM MEMBER'S PERCEPTIONS OF DEGREE OF  
MEMBER COMMITMENT TO TEAM DECISIONS

Discipline	n	Degree of Commitment to Team Decisions				
		No commitment A	B	moderate commitment C	D	Total commitment E
Audiologist	1				1	
Speech Therapists	2		1		1	
Psychologists	2			1	1	
Physicians	3				2	1
Social Workers	2				2	
Nursery School Teachers	2			1	1	
Total	12	-	1(8.3%)	2(16.7%)	8(66.7%)	1(8.3%)

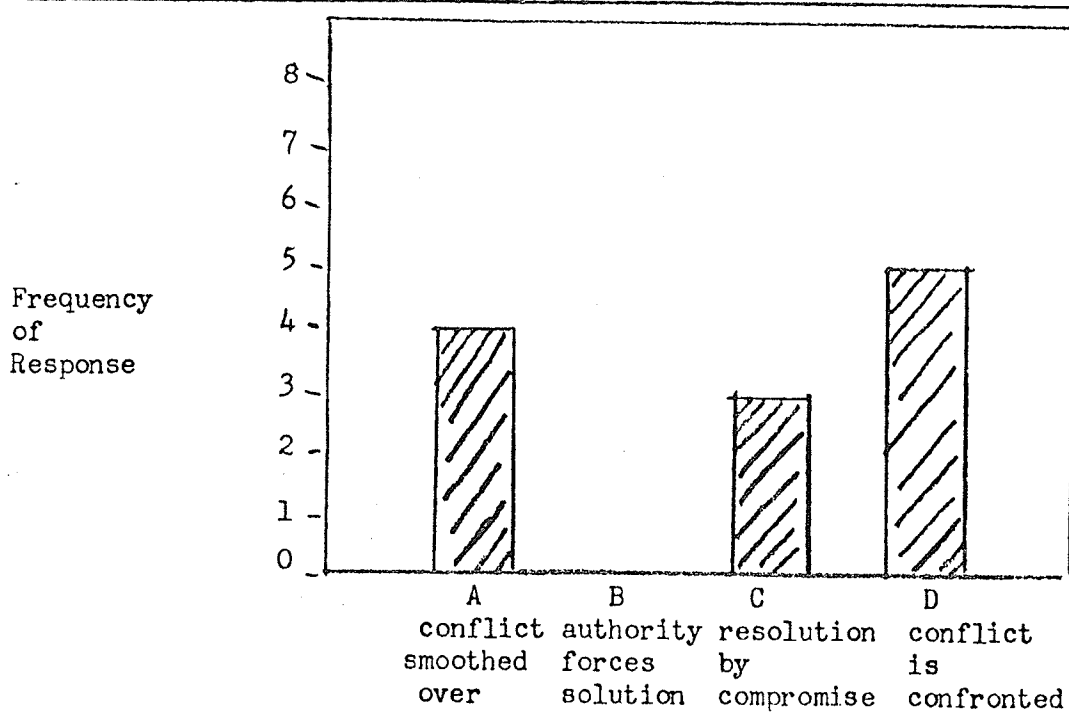
#### 6. Conflict Management on the Team

The usual pattern of conflict management on this team is not immediately obvious (see Table 63). 41.7% of the members feel that conflict is confronted, 25% feel it is resolved through compromise, and 33.3% feel that it is smoothed over. These findings duplicate those presented in Table 46, that is, 58.3% of the team members feel that conflict is not confronted. Table 64 shows that two physicians, the psychologists and one social worker are those members who feel that conflict is confronted.

Scale VI

TABLE 63

TEAM MEMBER'S OVERALL PERCEPTIONS OF PATTERNS OF CONFLICT RESOLUTION



PATTERNS OF CONFLICT RESOLUTION

Scale VI

TABLE 64

SPECIFIC TEAM MEMBER'S PERCEPTIONS OF PATTERNS OF CONFLICT RESOLUTION

Discipline	n	Patterns of Conflict Resolution			
		Conflict Smoothed Over A	Authority Forces Solution B	Resolution By Compromise C	Conflict is confronted D
Audiologist	1	1			
Speech Therapist	2			2	
Psychologists	2				2
Physicians	3			1	2
Social Workers	2	1			1
Nursery School Teachers	2	2			
<b>Total</b>	<b>12</b>	<b>4 (33.3%)</b>	<b>-</b>	<b>3 (25.0%)</b>	<b>5 (41.7%)</b>



### 7. Intermember Respect and Recognition

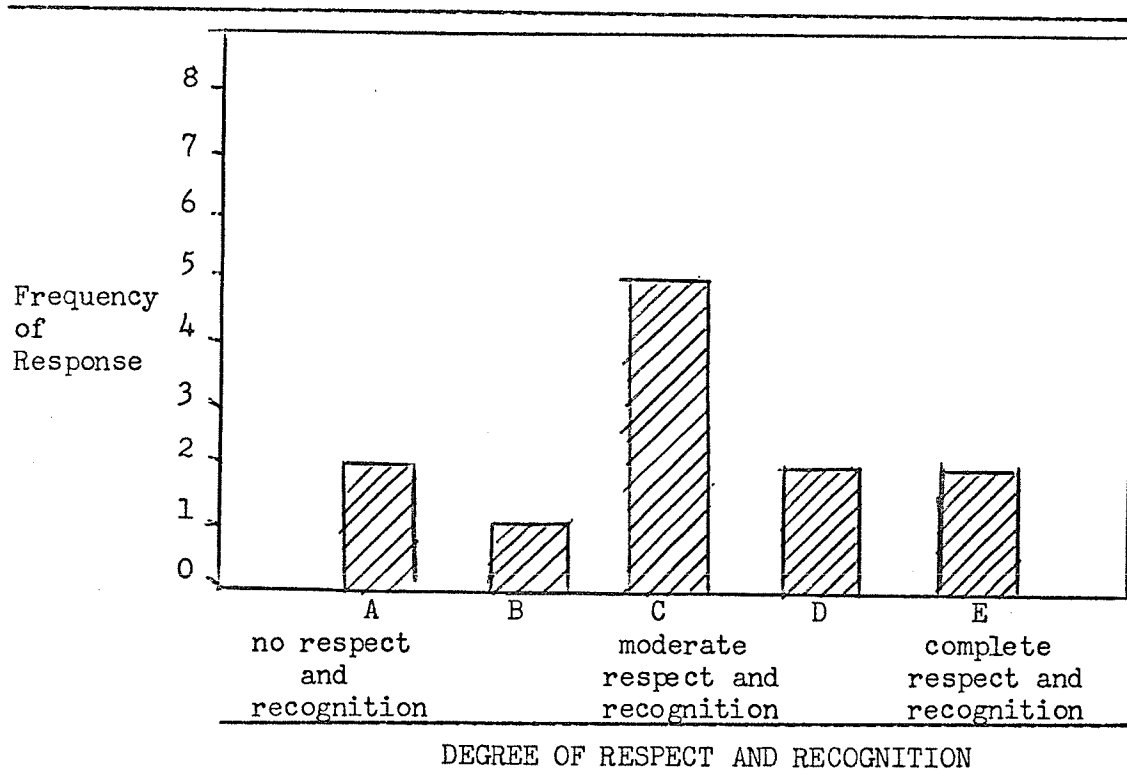
Table 65 indicates that there is no one common perception of the degree of intermember respect and recognition on this team, however, 75.1% of the team members feel that there is moderate to high degree of mutual respect and recognition shared by the team members. The audiologist, one nursery school teacher and one psychologist feel there is little to no intermember respect or recognition on the team. This finding is not duplicated elsewhere in the study as this question is not previously presented.

### 8. Cohesiveness on the Team

This team experiences a high degree of cohesiveness as indicated by 91.7% of the team members (see Table 67 and 68). One team member, a speech therapist, rates the degree of team cohesiveness as moderate. This question was not discussed in a comparable way in the previous section.

TABLE 65

TEAM MEMBER'S OVERALL PERCEPTIONS OF THE DEGREE  
INTERMEMBER RESPECT AND RECOGNITION



Scale VII

TABLE 66

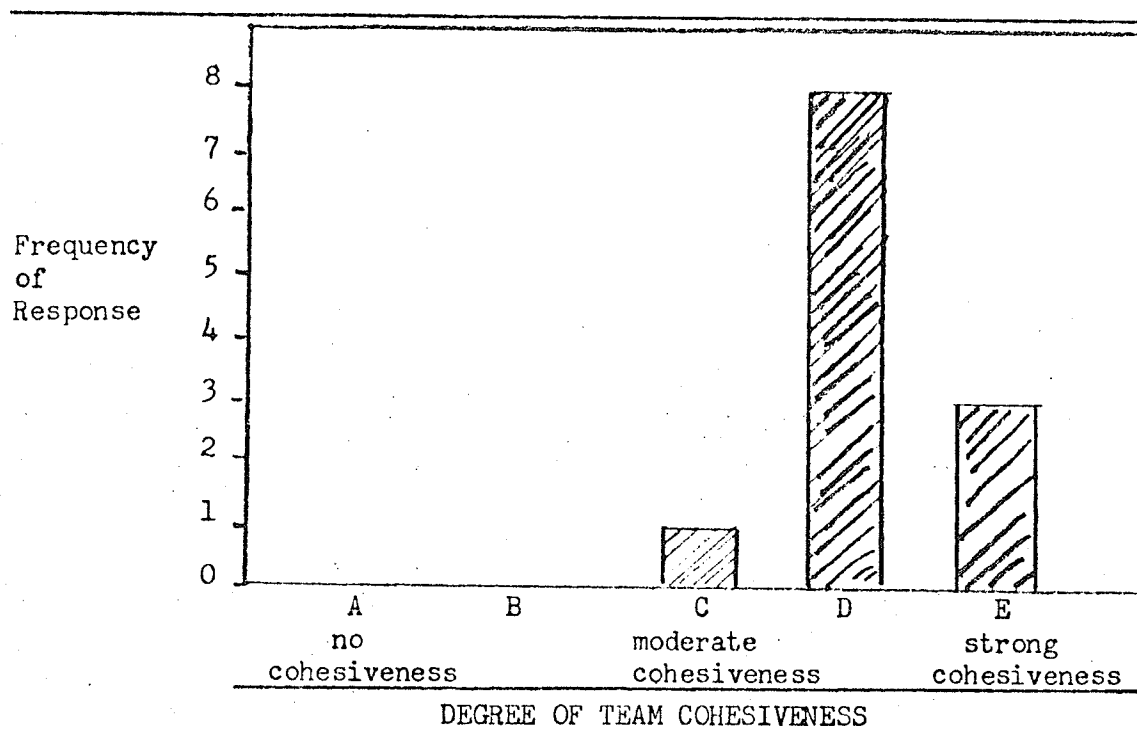
## SPECIFIC TEAM MEMBER'S PERCEPTIONS OF THE DEGREE OF INTERMEMBER RESPECT AND RECOGNITION

Discipline	n	Degree of Respect and Recognition				
		No respect and recognition A	B	Moderate respect and recognition C	D	Complete respect and recognition E
Audiologist	1	1				
Speech Therapists	2			1	1	
Psychologists	2		1	1		
Physicians	3			1		2
Social Workers	2			1	1	
Nursery School Teachers	2	1		1		
Total	12	2 (16.7%)	1 (8.3%)	5 (41.7%)	2 (16.7%)	2 (16.7%)

Scale VIII

TABLE 67

## TEAM MEMBER'S OVERALL PERCEPTIONS OF TEAM COHESIVENESS



Scale VIII

TABLE 68

## SPECIFIC TEAM MEMBER'S PERCEPTIONS OF TEAM COHESIVENESS

Discipline	n	Degree of Team Cohesiveness				
		no cohesiveness		moderate cohesiveness		strong cohesiveness
		A	B	C	D	E
Audiologists	1				1	
Speech Therapists	2			1	1	
Psychologists	2				2	
Physicians	3				1	2
Social Workers	2				1	1
Nursery School Teachers	2				2	
Total	12	-	-	1(8.3%)	8(66.7%)	3 (25.0%)

## II. CLIENT SAMPLE DEMOGRAPHICS AND CLIENT EVALUATION QUESTIONNAIRE

This section will present the client sample demographics as well as the findings from the Client Evaluation Questionnaire. These shall be presented in tabular form where possible and in narrative form where this is not possible.

The demographic information was obtained from the Supplementary Sheets (Appendix D) and from the patient files. Social histories were not available on the majority of cases but brief developmental histories provided some elements relevant to this section.

The sample consists of twenty-three cases all of which were new to C.D.C. in the month of March 1980. They have all been involved with more than one team member during their visits to the Clinic. A child was always the identified patient upon referral to the clinic and always presented with one or more of the eight identified problem categories as used by the Clinic on their intake records (see Appendix D). The mean age of the children in the total sample was 4.36 years with an age range of 10 months to 8 years and 10 months. The mean age of the respondent's children was 3.96 years with an age range of 10 months to 6 years (see Table 69).

TABLE 69  
AGE OF CHILDREN IN CLIENT SAMPLE

Age of Child	Frequency of Occurrence	
	Of total sample	Of Respondents
0 - 11 m.	2	1
1 y - 1 y - 6 m.	-	-
1 yr. - 7 m. - 1 yr. - 11 m.	-	-
2 yr. - 2 yr. - 11 m.	2	2
3 yr. - 4 yr. - 11 m.	9	6
5 yr. - 7 yr.	8	4
over 7 yr.	2	-
Total	23	13

$$\bar{x} = 4.36 \text{ yrs.} \quad \bar{x} = 3.96 \text{ yrs.}$$

Table 70 indicates that 10/23 of the total client sample children were referred for communication problems be they language, speech or hearing difficulties. Seven children were referred for behavior problems, two for kindergarten or school performance problems, two for custody or access problems, one for adoption or foster home problems and one for "other" which in this case was for the assessment of a cerebral hemorrhage and seizure episode.

TABLE 70  
PRESENTING PROBLEMS OF CLIENT SAMPLE

Presenting Problem <sup>1</sup>	Frequency of Occurrence of:	
	Total Sample	Respondents
Behavior Problem	7	3
Communication Problem*	10	7
Development Problem	-	
Kindergarten or school performance problem	2	1
Custody/Access Problem	2	2
Adoption/foster home problem	1	-
Research	-	-
Other	1	-
Total	23	13

\* many children with communication problems are simultaneously assessed for future school placement.

<sup>1</sup> categories developed by C.D.C. and used on patient Record Sheets (see Appendix D)

Of the respondent's children, three were referred for behavior problems, seven for communication problems, one for a kindergarten or school placement problem and two for custody/access problems.

Children and their families were referred to the Clinic most frequently by their community physicians. (See Table 71).

TABLE 71  
REFERRAL SOURCE OF CLIENT SAMPLE

Referral Source	Frequency of Occurrence of:	
	Total Client Sample	Respondents
Community physician	13	7
Social Service Agency Personnel*	7	3
Teachers*	1	-
Lawyers	2	2
No response	-	1
<b>Total</b>	<b>23</b>	<b>13</b>

\* in conjunction with community physician

The families and/or children in the total sample were seen by more than one team member. Table 72 indicates the professionals involved on each case as well as the primary focus of their casework. Physicians are involved in all but two cases and they work in various combinations with all team members. The emphasis of the casework in all but six cases contained some social elements, 13 cases involved a physical element, and six cases involved some psychological elements. Eleven cases involved a single focus, that being either social (8/11) or physical (3/11), while all others (12/23) involved a bi- or tri-focus. Of the respondents, physicians are involved in 12/13 cases and they work with all members of the team. Eleven cases involve a social focus in the casework and six have a double or triple focus.

TABLE 72

TEAM MEMBERS INVOLVED IN CASEWORK AND FOCUS OF  
THE CASEWORK RECORDED BY TYPE AND FREQUENCY OF CASES SEEN

Presenting Problem and Frequency of Respondents/ Frequency of Total Sample	Team Members Involved with Case	Primary Focus of Casework
Behavior Problem # of cases 1/3 0/1 1/1 0/1 <u>1/1</u> total 3/7	physician and social worker physician and neurologist consultant physician and nursery school teacher  physician and psychologist physician and psychologist	-social -physical & social -social  -social and psychologist -physical and psychological
Communication Problems #of cases 1/1 0/1 2/2 1/2 1/1 1/1 0/1 <u>1/1</u> total 7/10	physician, speech pathologist, audiologist and social worker  physician and psychologist  physician and speech pathologist (and consulting radiologist and plastic surgeon) audiologist and physician audiologist, speech therapist, psychologist speech therapist and physician speech therapist and physician audiologist, speech therapist and physician	-social  -social and psychological -physical  -physical -physical, social  -physical and social -social  -physical and social
Kindergarten and School Performance Problems #of cases <u>1/2</u> total 1/2	psychologist and physician	-physical, social and psychological

- continued on next page



TABLE 72 (CONT'D)

Presenting Problem and Frequency of Respondents/ Frequency of Total Sample	Team Members Involved with Case	Primary Focus of Casework
Custody/Access Problems #of cases <u>2/2</u> total 2/2	physician and social worker	-social
Adoption/foster home problems #of cases <u>0/1</u> total 0/1	speech therapist, psychologist, community social worker	-social, physical and psychological
Other #of cases <u>0/1</u> total 0/1	physician, social worker	-physical and social
Total 13/23		

The total client sample consists of 14 cases from Winnipeg and 9 cases from the surrounding rural areas. (see Table 73) Eleven of the cases come from families where the marriage is intact, three from "separated" families, two from "divorced" families, two cases are under government care, one is from a single (never married) parent family, and one is from a common-law union. The family status was not recorded in the file for three of the cases.

Of the respondents, 10 cases are from Winnipeg and three cases are from the surrounding rural areas. Five cases come from families which are intact, two from "separated" and two from "divorced" families. One case is "in care" and the family status for three cases was not documented.

TABLE 73  
FAMILY STATUS AND RESIDENCE OF CLIENT SAMPLE

Family Status	Residence	Frequency of Occurrence in:	
		Total Sample	Respondents
Separated	Winnipeg	3	2
	Rural Areas	-	-
Married	Winnipeg	7	5
	Rural Areas	4	-
Divorced	Winnipeg	2	2
	Rural Areas	-	-
Common-law	Winnipeg	1	-
	Rural Areas	-	-
Single Parent (never married)	Winnipeg	-	-
	Rural Areas	1	-
Children "in care"*	Winnipeg	-	-
	Rural Areas	2	1
Unknown	Winnipeg	1	1
	Rural Areas	2	2
Totals	Winnipeg	14	10
	Rural Areas	9	3
		23	13

\* Temporary or permanent government wardship

TABLE 74  
 CONCESSIONS MADE BY C.D.C. FOR  
 CLIENTS WITH SPECIAL NEEDS

Concessions for Patient's Special Needs	Frequency of Occurrence/ Frequency of Cases with Special Needs
-co-ordinated appointments for out-of-town clients	9/9
-assessments, tests in native language	1/1
Total	10/10

Table 74 indicates that the Clinic attempted to accommodate the special needs of ten out of ten clients who they feel indicated a special need. It should be noted that this data does not include cases with special needs that were not identified by the <sup>Clinic</sup> ~~Client~~ personnel.

Table 75 indicates that 76.9% of the clients perceive the C.D.C. as being helpful. It does not appear that the degree of perceived helpfulness is related to the client's presenting problem.

Table 76 indicates the type(s) of help the clients feel they have received or are receiving. Six cases (46.15%) received more than one kind of help. 46.2% of the cases feel that they received emotional support from the C.D.C. staff. The second most frequently (38.5%) cited form of help was the giving of information.

TABLE 75

CLIENT PERCEPTIONS OF HELPFULNESS OF C.D.C. AS  
RECORDED BY CLIENTS PRESENTING PROBLEM

Degree of Helpfulness	Presenting Problem	Frequency of Response	Percentage of Response
Very Helpful	Communication Problem	5	<u>8</u> (61.5%)
	Behavior Problem	2	
	Custody/Access Problem	1	
Somewhat Helpful	Custody/Access Problem	1	<u>2</u> (15.4%)
	Communication Problem	1	
Not Sure	Communication Problem	1	<u>2</u> (15.4%)
	School Placement Problem	1	
Somewhat Unhelpful	-	-	
Very Unhelpful	Behavior Problem	1	<u>1</u> (7.7%)
Total		13	100.0%

TABLE 76

CLIENTS PERCEPTIONS OF KINDS OF HELP GIVEN BY C.D.C.

Types of Help Given	Frequency of Response	Percentage of Response
treatment only	1	7.7
emotional support only	1	7.7
provided information only	1	7.7
emotional support/treatment	1	7.7
emotional support/information	2	15.4
emotional support/help with other agencies	1	7.7
all of the above	2	15.4
no response given	4	30.7
Total	13	100.0

The clients were asked "if C.D.C. had not been helpful, how could things have been done differently?" Only two respondents replied to this question. One respondent suggested that the C.D.C. staff review cases periodically as he felt that he had to demand a reassessment of his child's progress. The other felt that he had not been kept up to date on his child's progress, nor had his calls been returned. He also felt that he should have been referred to another agency for further help and follow up.

Table 77 indicates that 69.2% of the client contacts involving C.D.C. staff included one or both parents and the referred child. Table 78 indicates that 100% of the clients were contacted by at least two team members with the physician seeing 6/13 or 46.2% of the cases along with one or more other team members. (Refer to Table 72 for a specific breakdown of the focus of the casework.) Table 79 indicates the team member's contacts involving only the identified patient. 100% of the identified patients were seen by more than one team member with the physician(s) seeing 38.5% of these cases.

TABLE 77

CLIENT CONTACTS BY C.D.C. STAFF AS  
PERCEIVED BY CLIENT SAMPLE

Person Contacted	Frequency of Response	Percentage of Response
Referred child only	-	-
One parent* and patient	5	38.5
Both parents* and patient	4	30.7
Patient, Parents* and other family members	2	15.4
Others	-	-
No response given	2	15.4
Total	13	100.0

\* may be a foster, adoptive, "separated" or "divorced" parent

TABLE 78  
TEAM MEMBER'S CONTACTS WITH CLIENT SAMPLE

Frequency of Responses	Clients Contacted by:										
	social worker	psychologist	physician	audiologist	speech therapist	nursery school teacher	no response				
1	✓	-	✓	-	-	-	-	-	-	-	-
2	-	-	✓	-	✓	-	-	-	-	-	-
2	-	-	✓	✓	✓	-	-	-	-	-	-
1	✓	✓	-	-	-	-	-	-	-	-	-
1	-	-	✓	-	-	✓	-	-	-	-	-
2	-	✓	✓	-	-	-	-	-	-	-	-
1	✓	-	-	-	-	-	-	-	✓	-	-
1	-	✓	✓	✓	✓	-	-	-	-	-	-
2	-	-	-	-	-	-	-	-	-	-	✓✓
13 Total	3	3	6	2	3	2	2	2	2	2	2

\* contact made

TABLE 79  
TEAM MEMBER'S CONTACTS WITH THE REFERRED PATIENT

Frequency of Response	Child Contacted by:										
	social worker	psychologist	physician	audiologist	speech therapist	nursery school teacher	no response				
1	✓	-	✓	-	-	-	-	-	-	-	-
2	-	-	-	-	-	-	-	-	-	-	✓
2	-	-	✓	-	✓	-	-	-	-	-	-
2	-	-	✓	✓	✓	-	-	-	-	-	-
1	✓	✓	-	-	-	-	-	-	-	-	-
1	-	-	✓	-	-	-	-	-	-	✓	-
2	-	✓	✓	-	-	-	-	-	-	-	-
2	✓	✓	-	-	-	-	-	-	-	-	-
13	3	3	5	1	2	1	1	1	1	1	1

Table 80 indicates that 53.9% of the clients feel that the C.D.C. staff keeps them somewhat to well informed about treatment plans. 23% of the cases however feel that they are very uninformed. Of the 13 cases in the client sample, 7 or 53.9% remain active with the Clinic (see Table 81). Of the 6 cases who have terminated their involvement, four were because treatment/assessment was concluded, one is moving away, and one states that the Clinic failed to contact him for further appointments (see Table 82).

TABLE 80

CLIENT'S PERCEPTION OF DEGREE TO WHICH  
C.D.C. KEEPS THEM INFORMED

Degree Informed	Frequency of Response	Percentage of Response
very well informed	5	38.5
somewhat informed	2	15.4
not sure	1	7.7
somewhat uninformed	-	-
very uninformed	3	23.
no response given	2	15.4
Total	13	100.0

TABLE 81

CLIENT'S CURRENT INVOLVEMENT WITH C.D.C.

Concluded Treatment	Frequency of Response	Percentage of Response
Yes	6	46.1
No	7	53.9
Total	13	100.0



TABLE 82

## CLIENT'S REASONS FOR TERMINATION WITH C.D.C.

Reason for Termination	Frequency of Response	Percentage of Response
-treatment/assessment concluded	4	66.6
-dropped out*	1	16.7
-referred to another agency	-	-
-other**	1	16.7
Total	6	100.0

\* moving away

\*\* "C.D.C. failed to recontact me"

Table 83 indicates that 10/13 or 76.8% of the clients are either quite (23%) or very (53.8%) satisfied with the help they received at C.D.C. Tables 84 and 85 indicate that there is no apparent significant correlation between the clients' presenting problem, his place of residence, his family status or his degree of satisfaction with C.D.C.

TABLE 83

## CLIENT'S SATISFACTION WITH C.D.C.

Degree of Satisfaction	Frequency of Response	Percentage of Response
Totally satisfied	7	53.8
Quite satisfied	3	23.
Neither Satisfied nor Dissatisfied	1	7.7
Totally Dissatisfied	1	7.7
No response given	1	7.7
Total	13	100.0

TABLE 84

CLIENT'S SATISFACTION WITH C.D.C. AS  
RECORDED BY PRESENTING PROBLEM

Degree of Satisfaction	Presenting Problem	Frequency of Occurrence	Percentage of Occurrence
Totally Satisfied	-communication problem	3	53.8
	-behavior problem	2	
	-school placement problem	1	
	-custody/access problem	1	
Quite Satisfied	-communication problem	2	23.
	-custody/access problem	1	
Neither Satisfied nor Dissatisfied	-communication problem	1	7.7
Totally Dissatisfied	-behavior problem	1	7.7
No response	-communication problem	1	7.7
Total		13	100.0

TABLE 85

CLIENT'S SATISFACTION WITH C.D.C. AS  
RECORDED BY FAMILY STATUS AND RESIDENCE

Family Status	Residence	Degree Satisfied	Frequency of Occurrence	Percentage of Occurrence
Separated	Winnipeg	Totally Satisfied	1	15.4
		Totally Dissatisfied	1	
	Rural	-	-	
Married	Winnipeg	Quite Satisfied	2	38.5
		Neither Sat./Dissatisfied	1	
		Totally Satisfied	2	
	Rural	-	-	
Divorced	Winnipeg	Quite Satisfied	1	15.4
		Totally Satisfied	1	
	Rural	-	-	
Child "In Care"	Winnipeg		-	7.7
		Rural	Totally Satisfied	
Unknown	Winnipeg	Totally Satisfied	1	23.
		Rural	Totally Satisfied	
Total			13	100.0

Clients were asked to make any suggestions they wished for improving the service provided by the team at C.D.C. Only three clients responded. Their suggestions were as follows:

1. -keep parents well informed about the patient's diagnosis and prognosis  
-have regular case reviews to assess patient's progress and then adjust treatment plans as necessary
2. -keep parents informed about treatment plans  
-do regular follow-up (with patient and with family) once treatment is terminated  
-make referrals to other agencies for continuing help, support and treatment
3. -more play equipment in the Nursery School  
-provide reading material (to borrow or keep) for parents re: child's problem

### III. OTHER FINDINGS

It was thought to be of interest to present the demographics of those excluded from the Client Sample. These findings are presented in Appendix H.

## CHAPTER V

DISCUSSION OF THE FINDINGS

The material in this chapter will be presented in five sections. The first section will present a discussion of the findings under the following headings: team leadership, team member's roles, communication on the team, problem solving and decision-making on the team, the team's purpose, conflict on the team, the team and its environment, the client's perceptions of the service provided by the C.D.C. team, and the interprofessional relationships on the team. Section II shall present suggestions and recommendations for improving the team, and Section III shall present the implications of the findings. Section IV shall present the limitations of the study. Concluding comments shall be presented in Section IV.

Note: It may be helpful for the reader to review Brill's definition of the team and teamwork, and Watt's definition of the Medical Model as used in this paper before proceeding. Refer to Chapters I and II.

I. INTERPRETATION OF THE FINDINGS

The primary finding of this study is that the C.D.C. is comprised of a group of interdisciplinary professionals who work together towards a common purpose in the tradition of a modified medical model of team practice as defined by Watt (1973) (see Table 86). However, as such, they do not meet Brill's (1976) more idealistic definition of a team. The findings also indicate that C.D.C. is able to provide a satisfactory and helpful service to its clients, This group's strengths and weaknesses are also identified.

TABLE 86

## COMPARISON OF MEDICAL, LATERAL AND C.D.C. TEAM MODELS

Condition	C.D.C. Team Model	Medical Team Model	Lateral Team Model
Structure	mixture vertical and horizontal	vertical	horizontal
Leadership	-shared by many in casework issues otherwise physicians lead	physician	shared by many
Roles	-flexible with much overlapping across professions however, physicians have unique case co-ordinator role	-explicit and fixed and determined by professional membership	-flexible with much overlapping across professions
Communication	-sometimes decentralized; horizontal and informal in casework, but frequently centralized and vertical, yet informal in policy	-centralized; vertical and formal	-centralized with facility for feedback
Decision-Making and Problem Solving	-policy and procedures by authority; patient care by primary therapists	-vertical with minimal discussion	-shared with input from all
Purpose	-generally consensus rules in casework matters but minority rules in administrative issues	-authority rules	-consensus rules
	-implicit but shared by all	-general, with focus on diagnosing and curing patient's physical problems	-explicit; developed and shared by all
	-focus on providing comprehensive patient care to help patient achieve highest level of functioning		-focus on providing comprehensive patient care to help patients achieve highest level of functioning
Conflict	-detrimental and ignored unless disruptive, then confronted but not necessarily resolved	-detrimental and ignored	-valuable and resolved
Relationship with Host	-dependent on host but have some freedom in application of policy and procedure. Some members responsible to team; some to depts. outside of team.	-dependent on host; implements all policies and procedures as directed; all members responsible to own departments outside of team.	-interdependent; has freedom in application of policy and procedure; all members responsible to the team.

## Use of Group

-equal emphasis on task completion, keeping members happy, and keeping patients happy. Low mutual respect and recognition.

-emphasis on task completion; physician given respect and recognition but other members considered his assistants.

-equal emphasis on task completion, keeping members happy and keeping patients happy; respect and recognition shared by all.

---

#### A. TEAM LEADERSHIP

The findings indicate that the formal and the informal leaders of the C.D.C. team are both physicians but that they are perceived as sharing leadership responsibilities in casework matters with the primary therapists<sup>2</sup> involved with each case. However, it might be postulated that even in casework matters, leadership by the physicians prevails. That is, while the members feel that they are sharing the leadership role in casework, it may be that they are in reality, only allowed to make decisions and carry them out for as long as their actions compliment the physician's ideas and practices.<sup>3</sup>

In practice, the physicians do the majority of the intake and assessment of all new C.D.C. cases and also unilaterally decide which team members should be involved with each case, at least initially. The team members are then expected to carry out the physician's recommended assessment or treatment plans although there is room for the discussion of these plans between the primary therapist(s) and the physician(s). The psychologists are the only team members who appear to have established any significant leadership function on the team but their influence in these areas does not seem to be formally recognized by the physicians or the other team members.

Leadership which is dominated and controlled by the physicians especially in matters of treatment and patient care, is characteristic of

---

<sup>2</sup>The primary therapist is defined here as the team member who does the majority of the work with a case.

<sup>3</sup>This is known as "permissive" leadership. Refer to Chapter II for a more complete description.

the medical model of team practice. This process has been widely accepted in health teams probably because of the security and comfort it provides to the team's subordinate members. However, authors such as Brinkerhoff and Kunz (1972) suggest that as non-physician team members gain professional acceptance and self-confidence, they will begin to challenge the practice. It would appear however, that such a challenge would be futile unless the power structure on the team is altered to accommodate shared leadership.

These findings and observations suggest that the team's environment may preclude any increased involvement in the leadership role by non-physician team members except in a very limited sense. The member's apparent lack of desire to take a more formal or prominent leadership role on the team (see Table 11), is perhaps a realistic acknowledgement of this situation and not a reliable indication of their contentment with the practice. Whatever the case, this team's leadership style, which may be classed as permissive, remains characteristic of the modified<sup>4</sup> medical model of team practice.

#### B. TEAM MEMBER'S ROLES

It is interesting to note that while a great deal of role overlapping between all team members is noted (see Table 16), the physician(s) is ascribed with a unique role on this team, that of case overseer or case co-ordinator. The physician's co-ordinative role is in keeping with the medical model of team practice and is further suggestive of a permissive style of leadership.

---

<sup>4</sup>It is "modified" in that the practice has been tempered somewhat from the autocratic leadership style which is characteristic of the true medical mode/.



The findings suggest that the real and perceived roles of each member of this team are congruent (see Table 13), and that, as just noted, a great deal of role overlapping occurs between team members. Generally, team members have noted that the positive effects of this overlap are related to meeting the patient's complex needs as well as providing the professionals with collegial support and a more comprehensive assessment of the patient (see Table 18). However, while there are positive effects of such role overlapping, the system does have its flaws, especially when the team members are uncertain about the areas of overlap, and fail to discuss and co-ordinate their conterminous functions. Indeed, the negative effects of role overlapping in this team as cited by the team members, appear to be related to problematic communication and intermember relationships. That is, when the functions of two (or more) members involved with a case overlap, that overlap is rarely discussed. The result is neglected phases in the casework process, hurt feelings and petty jealousies between team members, and/or confusion for both the client and the staff members.

Overlapping of roles is considered to be a highly desirable characteristic in team practices but only when the team understands and accommodates the overlap. If the system fails to do this, a key characteristic of teamwork is missing that is, the communication and consolidation of the member's knowledge and skills. The failures in this team's use of its member's overlapping functions, appear to arise out of the disjointed and informal communication system which exists on this team (see Section C, this Chapter). There is no formal vehicle for co-ordinating casework between all the team members involved with a particular case, and therefore an opportunity to co-ordinate functions to provide comprehensive and continuous care to its clients is missed.

The working relationships between specific team members is discussed more fully in Sub-Section I of this chapter.

### C. COMMUNICATION ON THE TEAM

Communication on the team includes both written and verbal processes. The written communication process here refers to team records, and the verbal communication process refers to general rounds, staff meetings, and case conferences.<sup>5</sup>

The findings indicate that common team records are kept but that some team members also keep separate files as reminders of their case-work progress. Regular separate staff rounds are held but no en masse case conferences or staff meetings exist, yet all team members, except the physicians, note some dissatisfaction with the number and the existing functions of the meetings held (see Table 24). These members suggest that regular staff meetings be initiated for the purpose of discussing team policy and procedures, intermember conflicts, services offered by other team members and changes in H.S. which might affect C.D.C. As well, they suggest that regular en masse case conferences be held for the purpose of co-ordinating case reviews, planning and referrals, and for sharing case presentations.

It is interesting to note that because the physicians feel no need for additional meetings, none are held. It seems probable that the physicians see no need for additional meetings as they attend all existing

---

<sup>5</sup>On this team "general rounds" are defined as sessions attended by all team members where general information on new case management techniques, etc. are discussed. "Staff meetings" are defined as meetings which all members attend and at which intermember conflicts, and team policies and procedures are discussed. "Separate rounds" or "case conferences" are meetings which selected team members attend for the purpose of case planning and review.

rounds, co-ordinate the majority of the team's casework, and plan team policies and procedures. It is possible that they see these functions as exclusively their own and as a result, feel no need to share them with other team members. It is also noted that this system serves to retain the physician's power by not allowing group discussion of casework, team policy and procedures, and intermember conflicts. The team member's acceptance of this practice may be another indication of their realistic recognition and acceptance of the power distribution on this team. They seem to realize that changes in the present system will not occur unless the Director and his fellow physicians decide to allow such changes.

Some separate rounds or case conferences in which cases are discussed, are held for the social workers, and for the nursery school teachers. The physicians "chair" these meetings but the psychologists, who are invited to these sessions, do not always choose to attend. The audiologist and the speech therapists are excluded from these conferences.

This pattern of communication suggests that there are three groups of members functioning within this team. They are: 1) the physicians, social workers and nursery school teachers who are included in case conferences, 2) the psychologists, who sometimes choose to exclude themselves, and 3) the audiologists and the speech therapists who are excluded from case conferences. This differentiation between members suggests that the representatives of the disciplines on this team function in relatively independent ways from one another even though some of their functions overlap. This is not surprising in view of the lack of a formal facility for the co-ordination of member involvements in team casework.

The reasons for this practice are not immediately obvious but it would appear that the team members perceive the representatives of the speech and hearing professions as functioning primarily as the team's technical assistants and are therefore not needed in their conferences. The psychologist's independence on the other hand, may reflect this profession's traditional stance of taking a less subordinate role to the physicians than do most other helping professions (Zander, et al, 1957). Their independence can be further seen in the team's pattern of consultation wherein the psychologists are consulted by other team members almost as frequently as are the physicians (see Table 34). The social workers and the nursery school teachers, while independent of other team members, appear to have a very dependent relationship with the physicians<sup>6</sup>.

Somewhat surprising<sup>ly</sup>, the findings indicate that the team members describe the communication pattern on the team as being horizontal and informal (see Table 26). It is difficult to account for this finding as it does not appear to be congruent with the finding that while team members desire more meetings, none are held, nor with the irregular consultation patterns which exist between some team members. Further, it is not congruent with the fact that there is no vehicle for the discussion of issues from the bottom to the top of the hierarchy in matters of policy, procedures or intermember conflicts. In reality, other than for the casual, unrecorded consultations which do occur between some team members, there appears to be little horizontal

---

<sup>6</sup>Zander, et al (1957) notes that such member-physician dependency relationships exist in most health team situations.

communication on this team at present. In fact, the independent nature of each profession would almost seem to preclude the need for any additional horizontal and reciprocal communication.

The findings indicate that the team members perceive the team's present communication process to be effective (see Table 27) yet, they sight methods such as en masse case conferences, and staff meetings (refer to footnote 3), for improving it. The fact that the members have made no apparent attempt to have these suggestions implemented suggests: 1.) that they have accepted the limitations of the present structure and organization of the team which doesn't readily accommodate such changes, and 2.) that within the present structure and organization of the team, the existing communication process is effective, if perhaps less efficient than another process might be.

#### D. PROBLEM SOLVING AND DECISION-MAKING ON THE TEAM

It appears that the key decision areas in this team are firstly, those of case assignment, and policy and procedure making, and secondly, those of case treatment, referral and termination. Decisions about policy, procedure and case assignment determine what work is to be done, how it is to be carried out, as well as who is to do it. It is noted that these decisions are made primarily by the team physicians (see Table 28) thus making them the most influential and powerful members of the team. Decisions about treatment are made by the primary therapists and decisions about case termination/referral are made by the primary therapists and relevant others.

Case assignment by the physicians assumes that they have the expertise and skill necessary to assess the client's social, psychological,

and physical needs. While this may or may not be the case, this system is inefficient as it results in the underuse of the skills and expertise of the other team members. It may also result in the missed or incorrect diagnoses of clients' complex needs.

This system of case assignment whereby the physician makes decisions about case needs, assigns cases upon the basis of these needs and then expects that his plans for treatment will be carried out by the team members is characteristic of the medical model. It is considered to be antithetical to the lateral model of team practice in which decisions are based on the consolidation of relevant member's knowledge and expertise, in order to make the best possible decisions. The members have equal influence into the formulation and follow through of treatment plans.

In spite of this apparent dominance in decision-making by the physicians, the team members describe the overall decision-making process on this team as one of consensus (see Table 32). They also feel that their suggestions are sometimes if not usually followed in the decision process (see Table 40). The key to the apparent conflict between the member's perception and the actual decision-making process on this team, which more closely resembles decision by a minority, at least in matters of policy and procedure, seems to be the member's definition of a consensus. It appears that as individual members are sometimes consulted by the team leader about these issues, they assume, having no formal vehicle in which to confirm or negate it, that their opinions are in agreement with the other team members. As such, the member's cognizant sense of what constitutes a consensus appears to differ from that of a true consensus (refer to Chapter II). This being the case, little

importance can be attached to this question or to the member's response to it.

It is important to note that all team members retain some degree of independence (in treatment matters), while maintaining a dependent (in varying degrees) relationship with the team physicians. This practice is in keeping with the concept of teamwork but where the discrepancy arises is the degree to which the members are allowed ongoing involvement and influence in casework. That is, the physicians may refer or assign a case to one of the team members who subsequently makes an assessment and shares his recommendations for treatment with the physicians. If the physician then treats the patient without reciprocally sharing his plans and progress with the case with the consulted team member, the concept of teamwork has broken down.

This appears to be the case on this team in that the audiologists and speech therapists are not involved in any formal case conferences rather, they are treated as technical consultants to the team. However, it should be noted that there are exceptions to this practice. For example, the social worker's and the psychologists are sometimes allowed to remain involved with a case throughout its involvement with C.D.C. even if they are not the primary therapists.

The fact that the physicians can select who will become involved with a case as well as who will remain involved with it, means that they hold the most power on the team and as such, function as benevolent autocrats. The member's acceptance of this situation appears to be another example of their recognition of the rigidity of the present team's structure which doesn't allow the opportunity for equal member involvement, influence, or responsibility in a variety of issues confronting the team.

#### E. THE TEAM'S PURPOSE

The team members were unanimous in their descriptions of the team's purpose even though that purpose is not formally documented (see Tables 41 and 42). It is not surprising that the members all feel that this goal is congruent with their own personal goals as the global nature of the goal (ie. the provision of social, psychological and physical care to its clients) is broad enough to encompass the functions of each. As a result, each member can share a commitment to it.

It may be postulated that the team's present work processes of case assignment by physician, lack of formal case conferences involving all team members, and decision-making by a minority, do not allow for as an efficient and effective achievement of these goals as another model of team practice might. However, within the limits of this study, no definitive conclusion such as this can be made.

#### F. CONFLICT ON THE TEAM

It is interesting to note that the findings indicate that while all team members perceive some degree of conflict on this team, and generally consider it to be detrimental to the team's overall functioning, conflict is not confronted nor resolved (see Table 44). While confrontation of conflict is felt to be the healthiest method for handling differences (see Chapter II), only 41.6% of this team's members feel that this method is used. 51% of the members feel that conflict is either smoothed over or settled through compromise. These latter techniques leave conflict unresolved and lead to frustration and anger, and are often the source of many interpersonal difficulties (Rubin, et al, 1975). Legitimate differences between team members ultimately become petty personality attacks which serve to undermine the team's potential.



This would appear to be the case on this team for 75% of the members identify some negative elements in the climate on the team and 50% perceive conflict to be the result of personality clashes (see Table 45 and 46). Conceivably these conflicts originated as unresolved but legitimate differences between team members which have subsequently evolved into petty conflicts as a result of inadequate and inconsistent conflict management.

Unresolved conflict may also be at the root of another of this team's major weaknesses, disparity in the degree of intermember respect and recognition for the contributions of each to the team effort (see Table 65). Unresolved conflicts prevent and/or erode intermember respect and without respect and recognition, team members find it difficult to maintain the involvement with the job that is necessary in order for them to devote their full energy to the job and to the team's objectives (see Chapter II). The team's overall potential can be undermined as team members look for respect and acceptance elsewhere. Accordingly, Table 39 indicates that the audiologist, speech therapists and nursery school teachers are either unable to identify areas where they might contribute more to the team effort or, they identify new service areas outside of the team. All other professionals suggested areas which were just extensions of their present service involvement with the team. These findings may reflect the limited degree of respect and recognition these members experience on this team.

In view of these findings it is surprising to note that the team members describe the team's overall climate as quite satisfactory (see Table 48). This finding is not congruent with the acknowledged existence of unresolved conflict on the team. Nor is it congruent with the evidence

of disparity in member respect and recognition, unilateral leadership and decision-making as controlled by the physicians, nor the members expressed desire for increased involvement in administrative matters (ie. meetings to discuss policy and procedure). However, the team member's level of satisfaction is perhaps understandable in view of the fact that the members have generally been involved with each other for many years, and as a result, have developed and established patterns for coping with, rationalizing and/or overlooking what they consider to be minor dissatisfactions with the team's methods of getting its work done.

The other inconsistencies noted in the above paragraph are not as easily understood. However, it again appears that the team members have resigned themselves to the limitations of the structure and the organization of the present system. Such resignation is frequently noted among members of traditional health teams as the status quo provides comfort and security, and as noted, even if change was desired, this system is generally not accommodating.

Whatever the case, unacknowledged and unresolved conflicts stemming from legitimate differences between team members are frequently evidenced in medical models of team practice as the leaders and members aren't aware of, and don't value member differences. In the lateral model of team practice, conflict is valued, confronted and resolved.

#### G. THE TEAM AND ITS ENVIRONMENT (HOST ORGANIZATION)

The findings indicate that some of the C.D.C. team members function relatively independently from the H.S. Complex while others are under the direct supervision of their respective departments in H.S.

(see Table 50), a situation not uncommon in large hospital complexes. The audiologist, speech therapists and social workers are in this latter category. The social workers appear to be little affected by this split in responsibilities as they have a close and influential relationship with the team physicians and are not expected to provide service in the H.S. Complex. However, the speech and hearing professionals provide service outside of C.D.C. and have a minor influential role on the team. They describe the result of this situation as a feeling of anomie. That is, they do not feel part of C.D.C., nor do they feel part of their department in H.S.

Wise (1974) notes that such "splits in allegiance"<sup>7</sup> should be discouraged in team practices as they may serve as obstacles to the development of the team's full potential. The bureaucratic structure of the host organization is influential in maintaining this situation as it determines how close a supervisory relationship the team members will have with the C.D.C. Director. The audiologists, speech therapists and social workers have a looser supervisory link with the team leader than do the psychologists and the nursery school teachers. As noted, this appears to be a satisfactory situation for the social workers as they presently function in a relatively independent role from their department. The speech and hearing team members however, have great demands made upon their time by their department. This appears to be one contributing factor to these members' feelings of isolation. Their exclusion from case conferences, and the limited degree of respect and recognition that they feel on this team, are other contributing factors.

---

<sup>7</sup>Defined here as an obligation of a subject to its supervisory body.

While this system is not satisfactory to all team members, generally the members appear to have accepted this limitation/of the organizational structure of the team. The situation whereby the needs of some of the team members are subjugated in order to maintain the status quo, is however, antithetical to the concept of team practice, at least to the lateral model of team practice.

#### H. CLIENT PERCEPTIONS OF THE SERVICE PROVIDED BY THE C.D.C. TEAM

NOTE: The interpretations of the Client Evaluation Questionnaire are brief in comparison to the previous sections covered. This brevity is due to the small response rate of the client sample as well as the limitations of this instrument which preclude lengthy and complex interpretations.

The findings suggest that the client sample is generally satisfied with the service they receive and that their satisfaction is not related to which team member the client is involved with, the type of help he is receiving, his presenting problem, place of residence, nor family status (see Section II, Chapter IV). The only significant correlation appears to be with the degree of helpfulness C.D.C. is perceived to be by the client (see Table 75). That is, if the client perceives C.D.C. to be helpful, he is satisfied with its service.

Many new clients to C.D.C. are perceived as being in a crisis or pre-crisis state. As such, they may be greatly relieved and comforted by the knowledge that someone they perceive to be capable of offering assistance with their problems is working with them. The relief or emotional support that the clients experience may be the basis of the apparent satisfaction the clients feel with the service that C.D.C. has

provided for them. This satisfaction could conceivably decrease if the client remains in treatment and finds that C.D.C. is less helpful than he first thought.

Some clients did identify specific service areas which they felt could be improved. These were regular and consistent case follow-up and case reviews, and the provision of regular client progress reports. These functions which are not carried out as rigorously as the clients would like, appear to reflect the weaknesses in the team's communication and consultation processes which have been identified in the previous sub-sections. It can also be postulated that these problems reflect this team's apparent internal and possibly unconscious, interprofessional struggles for power and prestige. This team's leader and members appear unable or unwilling to shed some of the basic traditions of the medical model. There is a tendency for the physicians to lead the team while all other members follow. This is tempered somewhat by the sharing of some responsibilities in case management with the team members (see Section I, this Chapter), but there remains a disparity in status and equality between team members. This inequality influences how decisions and consultations are made, and strongly brings the existence of teamwork, as Watt and Brill define it, into question in this team.

#### I. INTER-PROFESSIONAL RELATIONSHIPS ON THE TEAM

The occurrence of rifts between professionals working together are well documented in the literature dealing with the rise of professionalism (Horwitz, 1970; French 1974; Bennis, 1966). Team practice, wherein professionals from many disciplines work together, is an obvious arena for such struggles and it would appear that this team is no exception.

The findings indicate that the audiologist, speech therapists and nursery school teachers are the team members who most consistently feel that this team is less than ideal in its functional level in the areas of role ambiguity and conflict, participation in decision-making, conflict resolution, and the degree of intermember respect and recognition (see Tables 56, 58, 60, 64 and 66). Interestingly, these members are also the newest members on this team (see Table 3). These findings when examined in conjunction with the team's consultation patterns, is a further indication that there are three types of members on this team as determined by their status and their degree of acceptance and influence. They are 1) the physicians, the social workers, and the nursery school teachers, 2) the psychologists, and 3) the audiologist and the speech therapists. The first two groups may be referred to as the primary team members, and the last group as the auxiliary team members.

Medicine, social work and psychology (along with Nursing) are the usual professions represented on health teams and as such, these team members have established their status and position. They attend case conferences if they choose and are more frequently consulted by the physicians than are any other team members. The nursery school teachers are included in this group, not as equals, but as the team members with the least amount of professional education (see Table 3) and the most in need of close supervision.

The audiologist and the speech therapists are highly educated technical experts who are not perceived to be in need of close supervision and are not included in case conferences. These members are part of a growing number of professions which are engaged in a broader struggle for recognition in various team settings. They have generally not yet

achieved wide acceptance nor equal status with the more traditional professions. Nor does it appear that they have achieved such recognition on this team.

It is interesting to note that the original article by Dr. W. W. Grant (1963), the founding Director of the C.D.C., in which Grant summarized the plans for the proposed Clinic, lists the "specific personnel" for the Clinic as: Medical Director and Assistant Director, one of whom would be a psychiatrist and one a pediatrician; a Clinical Psychologist; a Social Service Staff of two; a Nursery School Teacher and an assistant; two Secretaries; and one Medical Resident. He noted that "other professional personnel would be called on for assistance as necessary" (p. 83). These would be speech therapists, physical therapists and public health nurses. There is no reference made to these personnel as comprising a team.

Today the original founding professions have become the team members with the most influence and acceptance, and the "other" professions, the members with the least influence and acceptance.

This situation suggests that the founding philosophy and structure of the team has determined the team's work style and that this influence has held over time. It may be postulated that the problems resulting from the professional hierarchal arrangement on this team and the resulting discrepancies in member's perceptions of and satisfaction with the team's work processes could have been avoided, or at least reduced if the philosophy of equal status and recognition had been adopted from the team's inception, with work processes being planned accordingly and with all members having equal input into these plans. As noted, this group of professionals was never referred to, or perhaps

never intended to be a team other than in the style of the strict medical model. The fact that it has some elements of a modified medical model (ie. some shared leadership; some reciprocal case consultation) bespeaks the present team leader's benevolence.

## II. SUGGESTIONS AND RECOMMENDATIONS

The problem areas cited in the previous sections mean that although the team appears to be satisfactory to both its clients and its members, valuable time and energy are being drained from the tasks facing the team. Such factors as interprofessional struggles on the team, the remaining influences of the original organizational structure and philosophy of C.D.C., and the naivete or possible resistance of the team leader and members to adopt a more integrative model of team practice which calls for updated work processes, and equality of member influence and respect, must be overcome if the team's efficiency is to be increased.

TABLE 87

### MEMBER'S SUGGESTIONS FOR IMPROVING THE C.D.C. TEAM

Modification Needed	Purpose
-regular, formal case conferences, case reviews and case presentations	-improve referral, consultation and communication processes; demonstrate member's skills and abilities and thereby enhance intermember respect and recognition
-regular, formal staff meetings	-discuss and confront inter-member difficulties thereby eliminating need for petty conflicts.
-all team members responsible only to the team	-reduce feeling of anomie experienced by some members; increase team solidarity and cohesiveness

The C.D.C. team members and clients feel that the modifications noted in Table 88, if made, would make this team's practice more satisfactory to them. These changes in combination with a more formal and structured intake and referral process, a formal orientation program for



new team members, and an improved record keeping process could further enhance this team's efficiency. It is interesting to note that these changes would also make the team more characteristic of the lateral model of team practice by increasing the present level of member participation in decision-making, enhancing team cohesiveness, and confronting intermember differences. This finding might suggest that the lateral model of team practice would be more satisfactory to both its clients and its members than are other models of team practice, however, within the limits of this study such a conclusion can not be made. In fact, the team member's sustained commitment to and strong feeling of cohesiveness within the present team model may indicate that this practice model provides a satisfactory balance of dependence and independence for the members. Perhaps a lateral model of team practice would increase the member's anxiety level thereby decreasing their satisfaction with the practice.

### III. IMPLICATIONS OF THE FINDINGS

The previous section has identified many of this team's work processes and has noted that many of these processes are antithetical to the lateral model of team practice. These findings imply that this "team" is in reality a collection of interdisciplinary professionals who work together toward a common goal in the tradition of the modified medical model (as defined by Watt (1973). See Chapter II). However, as such, they do not meet Brill's (1976) more idealistic definition of a team.

Brill (1976) defines the team in the following way. The members form a system, that is, they individually and totally are subject to all the pressures and forces that operate within the group. The members are individuals with unique personalities, patterns of relating to others,

and ways of working, including all the essential elements of practice: values, knowledge and skill. The members share a common purpose which holds the group together. The C.D.C. team possesses all of these characteristics but it is missing the final element which Brill considers to be essential to ideal teamwork, the collective communication, collaboration and consolidation of knowledge as the basis for formulating actions.

The findings indicate that the structure and organization of this team are dominated and controlled by the team leader and his fellow physicians. They are the formal and informal leaders, they possess the most power and respect on the team, and they control the case consultations, decision-making and communication patterns on the team. The remaining team members vary in the degree of influence, respect and recognition they receive. In this way this team fails to meet Brill's definition of the lateral model of team practice.

In spite of the difference between this team's structure and organization and that of an ideal team practice, the findings indicate that the team members appear to have accepted this team's work practices and seem quite satisfied with them. Most surprisingly however, the findings indicate that the team member's perceptions of the team's structure and work processes are frequently distorted. For example, the members view the decision-making process on this team as one of consensus whereas in reality, it more closely resembles decision by a minority. They also view the communication process as horizontal while it is largely vertical in nature.

The many inconsistencies identified in the previous paragraphs provide much food for thought. One can not easily find reasons for them in the literature nor has this thesis clearly provided explanation.

For example, the very definition of what constitutes a team appears to require clarification. The literature provides various definitions of "team practice", but contributing authors admit that each team is a unique entity. Therefore, authors are forced into defining the team not as a body with a predetermined set of characteristics but as a unit which may lie anywhere on a continuum from vertical to horizontal as defined by their structural design. Watt (1973) has adopted this classification system in her work, but Brill is more specific, suggesting that unless the unit is of a lateral structure i.e., equality of member participation and respect in all areas, it does not constitute a team but is merely a unit which works together towards a common goal.

If this writer were to accept Brill's definition of the team, and it would appear prudent to do so, then C.D.C. can not be defined as a team. However, the question of whether C.D.C. constitutes a team or not, is not so easily resolved. Careful examination of the findings indicate that there are two streams operating in parallel, yet in very different ways within C.D.C. The policy and procedural issues at C.D.C. are managed in the tradition of the classic medical (vertical) model with the physicians making decisions and passing these along to the rest of the unit's members largely without benefit of discussion or feedback. Casework matters, on the other hand, are managed more in the tradition of the lateral model with many members sharing in the leadership and decision making processes. When the two streams - policy and casework - are melded together in order to facilitate the definition of this unit's overall work style, it appears that C.D.C. is a mixed model, but holding more characteristics of the medical model in common. Therefore, it would appear that C.D.C. can be defined as a modified medical model according to Watt's definition of 1973.

However, the question of C.D.C.'s "teamness" is still not answered, as the question still remains - a modified medical model of what, a team, or just a group which works together? This writer would suggest that it is the latter as there is little consolidation, coordination, or collaboration of knowledge between the members of C.D.C. as a basis for formulating actions. In so stating, this writer endorses Brill's belief that these ingredients are essential to teamwork. It is acknowledged that C.D.C. is deficit in this aspect of their unit's functioning.

It would now appear that the question of whether C.D.C. constitutes a team practice has been satisfactorily answered. However, it has not. One further inconsistency remains, with which we must deal. While C.D.C. is not structured laterally in many areas, its members feel like a team. It would appear that C.D.C.'s members want to be a team, perceive themselves to be a team, and although they admit that there are minor flaws in their work practices, they are generally satisfied with how their "team" functions. The factor which promotes such unity and cohesion appears to be the member's shared attitude and perception that they are indeed a team. But, how can this incongruity be explained and made compatible with the existing prescriptions for team practices?

Brill suggests that a work unit is a team when its structure dictates equality of participation and recognition in decision making and problem solving. This writer would suggest that while Brill's definition is improved over those definitions which include vertical work units as teams, it too is deficient. It fails to account for the human factor of emotions and attitudes which can not be defined nor ignored whenever human beings come together. Will mere structure make a group of individuals work

as a team? Probably not, for without member trust and willingness to cooperate, a "team" will still encounter jealousies, conflicts and ultimately will lack cohesion and solidarity. This observation therefore suggests that both structural and attitudinal/emotional components must be included in any comprehensive definition of the team and its practices.

(As an outside, the reader may wonder why the C.D.C. members so strongly wish to be a team, yet fail to take the initiative to convert their unit into a functional lateral team. It is suggested that the member's desire to have the unit function as a team, is accompanied by their collective, yet perhaps unconscious fear that the unit could not withstand the revelation and confrontation of their dissatisfaction with its current practices. It is postulated that the members rationalize their illusionary team's weaknesses as minor inconveniences in order to maintain the status quo.)

Several questions which were not dealt with in any depth in this thesis and which remain to be investigated in order to determine what influences and determines how and when a work unit can be defined as a team will be discussed briefly in the following paragraphs.

The writer feels that it might be important to determine how the various members of C.D.C. anticipated that the "team" would work at the point at which they made a commitment to join it. Similarly, what did they anticipate their role to be with the "team"? What factors and influences led them to join C.D.C? What were their expected rewards? It might also be important to examine how unclear role sets and implicit goals have shaped the member's roles in, and attitudes towards C.D.C.? Do other roles, professional and social, influence member attitudes and expectations about C.D.C.? Do male and female members, apart from their professional affiliations, have varying perceptions of, and satisfactions with their roles

at C.D.C.? What are the rewards which sustain their commitment to the "team"?

As noted, these issues are not dealt with in this thesis and therefore one can only postulate about the answers to them. This writer would suggest however, that individual members of C.D.C. initially made a commitment to the unit expecting to play an equal and respected role in a team made up of representatives from various disciplines who would together consolidate knowledge and skills in all areas of intake, assessment, planning, treatment and follow-up. Today at C.D.C. it appears that the members with the lengthiest involvements with the unit have generally resolved major conflicts between their anticipated and actual roles and involvements in the unit. The newer members do not appear to have resolved such conflicts and therefore acknowledge the most dissatisfaction with the unit's practices. Nonetheless, as a group, the member's commitment to the idea of team practice seems to have sustained their interest and involvement with the Clinic.

Another issue which is unresolved in the literature and for which there is a need for further research is the question of whether lateral teams can work in all situations, or are they even practical or viable in some settings? C.D.C. is located in one wing of the Health Sciences Complex, a large hospital setting. This hospital as most others, operates as a highly structured bureaucratic organization. Its primary focus is the provision of health care services to its patrons. At present, in medical settings where life and death decisions are made, the medical authorities take primary responsibility for treatment decisions. Is it realistic then to expect a Clinic, within the auspices of such an organization, to function as a democratic team with participation and responsibility shared equally by all? The writer would suggest that it is not. Therefore, until

a trend for legal accountability equally shared, by all health professionals on a team, is shown by the courts and by the public at large, it does not seem realistic to expect a physician to trust his co-workers unquestionably while maintaining full legal responsibility for their actions.

#### IV. LIMITATIONS OF THE STUDY

No major difficulties were encountered in obtaining the data for this study other than those which are common to mailed questionnaires and interview techniques or which were due to lost or misplaced data. However, it is recognized that this study had the following limitations which were taken into consideration in the problem formulation stage of the research:

- a) it was not possible within this study to evaluate the success and efficiency of this team practice in relationship to other team practices;
- b) it was not possible to examine the "quality of care" provided by this team except in a very limited sense;
- c) it was not possible to manipulate the variables involved in team practices as the relevant variables have not yet been identified.

The following more specific limitations relate to the data collection phase of this study:

- a) the team sample includes only the professional members of the team, the secretaries have not been included as the literature is not conclusive about their consideration as full team members (Wise, 1974);
- b) the client sample includes only those cases which were new to C.D.C. in March 1980 and which were seen by more than one team member. This

- criteria was followed in order to provide the cases with a common starting point and to ensure that all cases were subject to interdisciplinary teamwork and not just the casework of one team member;
- c) the data was collected over a period from March 1, 1980 to April 30, 1980. There may be particular seasonal aspects of cases referred to C.D.C. which are not controlled for in this study;
  - d) the research techniques employed in the study do not provide for the rigid control of such extraneous and complicating factors as response set, and the Hawthorne effect. However, these variables were taken into account in any interpretation of the findings.

The instruments used, although previously untested and prone to subjectivity, are thought to have proven useful and effective for obtaining the data required for this study. While their reliability and validity have not been established, it is noted that the findings using the various instruments appear to support one another. This would seem to suggest that the instruments hold some degree of validity.

The response rate for the Client Evaluation Questionnaire, 56.56% fell short of the goal of at least 66 2/3%. However, this response rate still allows for the cautious drawing of conclusions from responses received.

It is acknowledged that the findings presented in Chapter IV do not establish casual relationships nor are they widely generalizable across settings. These findings also do not make it possible to define the organizational elements that are required for a team to reach its full potential of productivity, efficiency and effectiveness. The findings do however, make it possible to define the parameters of this team's structure and work style as was the purpose of this study.



## CONCLUSION

The research findings in this thesis have identified the work practices of the Child Development Clinic. Following Brill's (1976) definition of a team, and disregarding the C.D.C.'s member's feelings that they are a team, the findings illustrate that C.D.C. is not a team rather it is a collection of interdisciplinary professionals working together towards a common goal. They are missing the essential element of team practice, as defined by Brill, in that they fail to collectively communicate, collaborate and consolidate their knowledge and skills as the basis for formulating actions. The fact that the C.D.C. members feel like a team is not considered in Brill's concept of the ideal team model.

While Brill advances the knowledge base about team practice by suggesting some elements essential for a work unit to be defined as a team, she fails to include the element of human emotion in her concept. The findings and their implications strongly suggest that Brill's definition of teamwork is deficit in this regard for while formally (structurally) C.D.C. can be defined as a collection of individuals working towards a common goal, informally (attitudinally), this unit constitutes a team. This suggests that any comprehensive definition of a team should include both formal structural components and informal attitudinal and emotional components.

In summary, while this thesis has fulfilled its purpose of defining one "team's" practice, it has also brought into focus the key question which needs answering in future research into team practices, that is, when is a team, a team? This thesis has attempted to provide a starting point from which more sophisticated definitions and research methods may be developed and from which many such hypothesis for future study may be extrapolated.

## APPENDIX "A"

KOOPI'S  
ANALYTICAL FRAMEWORK

Work Process 1: Interactional processes between the individual and the team:

Work Styles

	<u>Coordinative</u>	<u>Integrative</u>
1.) role definition and negotiation.	<ul style="list-style-type: none"> <li>-define professional role in team of other professionals.</li> <li>-formal collaboration about professional contribution to a specific service task.</li> <li>-some interplay of personalities; restricted by rigid adherence to traditional professional roles.</li> </ul>	<ul style="list-style-type: none"> <li>-not directed at defining individualized professional roles.</li> <li>-informal and/or formal interaction re: individual contribution to service task.</li> <li>-regular interplay of personalities and professional skills.</li> <li>-a dynamic process.</li> </ul>

Work Process 2: The team's functional use of group processes:

1.) for team maintenance.	<ul style="list-style-type: none"> <li>-little effort to use group processes for team building and maintenance.</li> <li>-group processes are not used to obtain cohesion and solidarity.</li> </ul>	<ul style="list-style-type: none"> <li>-a great deal of effort to use group processes for team building, development, and maintenance.</li> <li>-group processes are used to obtain solidarity and to encourage interdependent collaboration.</li> </ul>
2.) for task accomplishment.	<ul style="list-style-type: none"> <li>-group processes are used to facilitate the sequencing of tasks. (case conferences, information-sharing, negotiation of specific tasks).</li> </ul>	<ul style="list-style-type: none"> <li>-group processes used to strengthen interdependent collaboration.</li> <li>-group processes are also used to assign, distribute, and integrate approaches to service delivery.</li> </ul>

Work Process 3: The definition of the team's purpose:

## 1.) goal-setting and goal-ordering processes

## a.) goal formulation:

- |                                |                                     |                                                  |
|--------------------------------|-------------------------------------|--------------------------------------------------|
| i.) overall goals of the team. | -assigned by hierarchial authority. | -established by the interaction of team members. |
| ii.) task goals.               | -independent and/or competitive.    | -interdependent and/or collaborative.            |

## b.) commitment to goals.

- |                                                                   |                                                                                                  |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| -commitment to task and program goals, rather than to team goals. | -commitment to the overall goals of the team, commitment to task and program goals is secondary. |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|

## c.) specificity of goals.

- |                                                                                                               |                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| -overall goals of team remain at a broad, general level; task and program goals are specific and operational. | -overall goals of team are specific and operational; task and program goals are integrated into the team goal structure. |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|

Work Process 4: Decision-making processes in the team:

## 1.) decision-makers:

- |                                           |                                             |        |
|-------------------------------------------|---------------------------------------------|--------|
| a.) decisions effecting the overall team. | -designated leader and program authorities. | -team. |
|-------------------------------------------|---------------------------------------------|--------|

## b.) task decisions.

- |                                                                         |                                                 |
|-------------------------------------------------------------------------|-------------------------------------------------|
| -made independently by team members.                                    | -team, via interdependent collaboration.        |
| -formal agreement of tasks by team members involved in case conference. | -individual team members in cases of emergency. |

## 2.) types of decisions:

- |                                           |                                                        |                                                                    |
|-------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------|
| a.) decisions effecting the overall team. | -the administrative coordination of independent progs. | -the establishment of goals.                                       |
|                                           | -the establishment of goals.                           | -the delegation of tasks according to the nature of the situation. |
|                                           | -the delegation of tasks according to programs.        | -the assessment of community needs.                                |
|                                           | -the formation of new policies and procedures.         | -the formation of new policies and procedures.                     |

- |                                           |                                                                                |                                       |
|-------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------|
|                                           | -the hiring of new staff.                                                      | -the hiring of new team members.      |
|                                           |                                                                                | -the work scheduling of team members. |
| b.) task decisions.                       | -the assignment of client needs.                                               |                                       |
|                                           | -the choice of strategies to meet these needs.                                 | -same.                                |
|                                           | -treatment of the problem.                                                     |                                       |
|                                           | -evaluation of the outcomes.                                                   |                                       |
| 3.) methods of decision-making:           |                                                                                |                                       |
| a.) decisions effecting the overall team. | -by lack of response.                                                          | -by lack of response.                 |
|                                           | -by authority rule.                                                            | -by minority rule.                    |
|                                           | -by minority rule.                                                             | -by majority rule.                    |
|                                           | -by majority rule.                                                             | -by consensus.                        |
|                                           |                                                                                | -by unanimous consent.                |
| b.) task decisions.                       | -primarily individual decisions.                                               | -same as above.                       |
|                                           | -formal case conferences employ; authority rule, minority rule, majority rule. |                                       |

Work Process 5: Conflict resolution processes in the team:

- |                                                       |                                                                                                   |                                                                                                |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1.) attitude toward conflict.                         | -conflict is dangerous and must be eliminated.                                                    | -conflict is productive and needs to be managed effectively.                                   |
| 2.) conflict resolution processes.                    | -bargaining processes.                                                                            | -analytic processes.                                                                           |
| 3.) by-products of the conflict resolution processes. | -a climate of high anxiety and frustration, because many unresolved and unrecognized differences. | -a climate of low anxiety and frustration, because differences are recognized if not resolved. |

Work Process 6: Communication processes in the team:

- |                                       |                          |                              |
|---------------------------------------|--------------------------|------------------------------|
| 1.) intra-team communication network. | -formal and centralized. | -informal and decentralized. |
|---------------------------------------|--------------------------|------------------------------|

- |                                    |                                                                                               |                                                                                 |
|------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
|                                    | -frequency, order, and content of participation follows formal lines of authority and status. | -frequency, order, and content of participation is uninhibited and spontaneous. |
| 2.) record-keeping system. ✓       | -individualized and independent.                                                              | -centralized recording system.                                                  |
| 3.) built in evaluation process. ✓ | -does not have a built in evaluation process.                                                 | -has a built in evaluation process.                                             |

Work Process 7: The definition and practice of leadership and authority in the team:

1.) positions of leadership authority:

- |                                        |                                                                        |                                                                                           |
|----------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| a.) authority to deploy staff.         | -program authorities, and/or the authorities of the host organization. | -team.<br>a designated leader is responsible to facilitate and manage the team processes. |
| b.) authority to assign tasks (cases). | -designated leader of the team.                                        | -team.                                                                                    |
| 2.) source of power:                   |                                                                        |                                                                                           |
| a.) legitimate.                        | -high degree.                                                          | -moderate to low.                                                                         |
| b.) reward.                            | -moderate to high.                                                     | -moderate to high.                                                                        |
| c.) coercion.                          | -low to moderate.                                                      | -low.                                                                                     |
| d.) referent.                          | -low.                                                                  | -low to moderate.                                                                         |
| e.) expert.                            | -low to moderate.                                                      | -high.                                                                                    |
| 3.) leadership styles:                 | -boss-centered leadership.                                             | -subordinate-centered leadership.                                                         |

Work Process 8: Interactional processes of the team and its environment (host organization, reference groups, and community):

1.) host organization:

- |                                          |                                                                           |                                                                                                     |
|------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| a.) definition of functional boundaries. | -accept the functional boundaries as determined by the host organization. | -attempt to determine their functional boundaries through collaboration with the host organization. |
|                                          | -operationalize the rules, roles and procedures of the host organization. | -attempts to alter the rules, roles, and procedures of the host organization.                       |

b.) expectations regarding worker commitment.

-supportive to host organization and its goal of self preservation.

-supportive to their team.

2.) professional reference groups:

a.) allegiance and loyalty of team member.

-a separation of allegiances between the team and the profess. reference group.

-a blurring and integration of allegiances between the team and the profess. reference group.

b.) value system of the team member.

-expected to adhere to professional value system.

-expected to adhere to team value system.

3.) consumer accessibility to team resources.

-limited access to the total team resources.

-access to the total team resources.

INTERVIEW SCHEDULE

## Staff Background Sheet

NAME:

EDUCATIONAL BACKGROUND: (Please identify your level of education by degree or diplomas held by you. Also please note any diplomas/degrees towards which you are actively working.)

PREVIOUS TEAM RELATED EXPERIENCE: (Please note the duration, role, description of work, and location.)

I. TEAM MEMBERS

## (a) Leadership:

Who is the designated leader on this team? \_\_\_\_\_

Do other team members have an opportunity to share leadership? \_\_\_\_\_

If so, who does? \_\_\_\_\_

Who rarely does? \_\_\_\_\_

Would you describe the leadership style of the designated leaders as: \_\_\_ autocratic \_\_\_ laissez-faire \_\_\_ democratic

Is there an informal leader as well as designated leader on this team? \_\_\_\_\_

If yes, who? \_\_\_\_\_

Would you like an opportunity to lead this team? \_\_\_\_\_

\_\_\_ Strongly like \_\_\_ Like \_\_\_ Undecided \_\_\_ Dislike  
\_\_\_ Strongly Dislike

Does the leader put most emphasis on: (please check one)

- (a) \_\_\_ Task completion  
 (b) \_\_\_ Keeping team members happy  
 (c) \_\_\_ Keeping patients happy  
 (d) \_\_\_ Equal emphasis on a, b and c  
 (e) \_\_\_ Other (please specify) \_\_\_\_\_

Additional Comments: \_\_\_\_\_

## (b) Your Role:

What is your role on the team? \_\_\_\_\_

Do you feel that you could renegotiate your role to take on/drop some responsibilities? \_\_\_\_\_

How would you go about renegotiating? \_\_\_\_\_



To what extent does your role overlap with other team member's roles?

\_\_\_ A great deal    \_\_\_ Somewhat    \_\_\_ Not sure  
                   \_\_\_ Hardly at all    \_\_\_ Not at all

If yes, whose role and how do they overlap? \_\_\_\_\_

\_\_\_\_\_

What are the consequences of this overlap to you and to the team as a whole?

\_\_\_\_\_

\_\_\_\_\_

What do you see as the primary role of the following team members:

Physician: \_\_\_\_\_

Psychologist: \_\_\_\_\_

Nursery School Teacher: \_\_\_\_\_

Audiologist: \_\_\_\_\_

Speech Therapist: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Could they be doing more than they are? \_\_\_\_\_

If yes, what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## II. COMMUNICATION

### (a) Record Keeping:

Are there common team records kept?    \_\_\_ Yes    \_\_\_ No

Do you contribute to them?    \_\_\_ Yes    \_\_\_ No

What material do you contribute? \_\_\_\_\_  
 \_\_\_\_\_

Do you also keep private files on the cases you are involved with?

\_\_\_ Yes                      \_\_\_ No

What goes into these files? \_\_\_\_\_  
 \_\_\_\_\_

Do you share your private files with other team members?

\_\_\_ Yes                      \_\_\_ No

If yes, with whom and for what purpose? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(b) Staff Meetings, Case Conferences, Rounds, etc.

Are regular staff meetings held?    \_\_\_ Yes            \_\_\_ No

If yes, how often are they held? \_\_\_\_\_  
 \_\_\_\_\_

Who attends them? \_\_\_\_\_  
 \_\_\_\_\_

What is their function? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Would you like (more) meetings to be held? \_\_\_\_\_

Why? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How would you describe the communication network on this team--vertical, horizontal, formal, informal, etc.? Explain.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How effective is the communication system on this team?

\_\_\_ Effective    \_\_\_ Somewhat effective    \_\_\_ Not Sure  
                  \_\_\_ Somewhat ineffective    \_\_\_ Ineffective

What are the difficulties with the system? \_\_\_\_\_  
 \_\_\_\_\_

How could it be improved? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### III. PROBLEM SOLVING AND DECISION MAKING

Who is the primary decision maker on this team with regard to:

Policy making? \_\_\_\_\_

Treatment Choice? \_\_\_\_\_

Case termination or referral to another agency? \_\_\_\_\_

Case assignment? \_\_\_\_\_

How much influence do you feel you have in the overall decision making process on this team?

\_\_\_ A lot of influence    \_\_\_ Some influence    \_\_\_ Not Sure  
           \_\_\_ Little influence    \_\_\_ No influence

In what types of decisions do you have input and influence?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

In what types of decisions do you have no input or influence?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How satisfied are you with the amount of influence you are allowed?

\_\_\_ Very satisfied    \_\_\_ Quite satisfied    \_\_\_ Not Sure  
           \_\_\_ Quite dissatisfied    \_\_\_ Very dissatisfied

How could this process be improved? \_\_\_\_\_

What is the usual pattern of decision making in this team?  
 (Majority rules, minority rules, consensus, authority rules, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To what extent does the leader encourage consultation with other team members? (cont'd on next page)

\_\_\_ Strongly encourages \_\_\_ Encourages somewhat \_\_\_ Not sure  
 \_\_\_ Discourages somewhat \_\_\_ Strongly discourages

Who do you consult with most frequently? \_\_\_\_\_

Least frequently? \_\_\_\_\_

How helpful do you find intermember consultation?

\_\_\_ Very helpful \_\_\_ Somewhat helpful \_\_\_ Not sure  
 \_\_\_ Somewhat unhelpful \_\_\_ Unhelpful

How could consultation be used better by the team? \_\_\_\_\_

Do you feel that clients generally perceive that they are  
 being served by a team? \_\_\_ Yes \_\_\_ No

How would they know/not know this? \_\_\_\_\_

Do you feel that this contributes to the client's satisfaction  
 with the service they receive? Why?

Additional Comments:

#### IV. TASK ASSIGNMENT

Who assigns the cases to the various team members and on what  
 basis are they assigned? \_\_\_\_\_

What kinds of cases do you usually see? \_\_\_\_\_

What kinds of cases should you be seeing? \_\_\_\_\_

\_\_\_\_\_

Do you have an opportunity to work with the cases which interest you or which you feel most professionally qualified to deal with? \_\_\_\_\_

\_\_\_\_\_

To what degree do you feel that your suggestions for treatment of the cases are generally acted upon?

\_\_\_ Always acted upon    \_\_\_ Sometimes acted upon    \_\_\_ Not sure  
       \_\_\_ Sometimes rejected    \_\_\_ Always rejected or ignored

#### IV. TEAM PURPOSE

What is the team's purpose or mandate? \_\_\_\_\_

\_\_\_\_\_

What is your specific purpose? \_\_\_\_\_

\_\_\_\_\_

Is there any conflict between the two? If so, how do you resolve it? \_\_\_\_\_

\_\_\_\_\_

Is the team purpose formalized or is it assumed that all team members know the purpose and share a commitment to it?

\_\_\_\_\_

What is the focus of the team with regard to meeting patient's needs? (Please check the one which best applies to this team.)

- (a) \_\_\_ physical  
 (b) \_\_\_ psychological  
 (c) \_\_\_ social  
 (d) \_\_\_ a,b,c are equally important  
 (e) \_\_\_ Other (please specify) \_\_\_\_\_

\_\_\_\_\_

VI. CONFLICT

How much conflict is there on this team?

a great deal  some  not sure  little  none

What issues seem to cause the most conflict? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How is conflict viewed and dealt with on this team? (Please check one reply from column A plus one from column B.)

A	Conflict is:	B
Thought to be valuable to the team.		Ignored and left unresolved.
Thought to be detrimental to the team.		Confronted and resolved.

How would you describe the climate on this team? (Please check one answer)

- Open and respectful
  - Anxiety is high
  - Frustration
  - Discontent
  - General satisfaction
  - Intramember distrust and paranoia
- \_\_\_\_\_
- \_\_\_\_\_

How satisfied are you with the climate on the team?

Very satisfied  Quite satisfied  Not sure

Quite dissatisfied  Very dissatisfied

Do you have any suggestions for better handling of conflict on the team? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

VII. ENVIRONMENT

Who is your direct supervisor? \_\_\_\_\_

Do you have other responsibilities at HS outside of CDC? Please specify. \_\_\_\_\_

\_\_\_\_\_



DIRECTIONS

In the scales on the following pages, circle the letter that you think most accurately reflects where your own description of your team would fall between the two descriptive statements provided (I and II). Read both statements before deciding on your response. If your description is more like the top statement (I), then you should circle letter "a" or letter "b". If your description is more like the bottom statement (II), then you should circle "d" or "e". Your answer should represent how you think things actually are, not how they should be or you wish they were.

1. Statement I - I often wonder what is the basic reason for being here. It seems to me that there are people on the team (maybe even myself) who spend a lot of time and energy doing things that are not consistent with what I think is our main purpose in being here. They downplay or overlook important parts of our total objective or their time is directed at things I think aren't very important.

- a. Just like I
- b. More like I than II
- c. In between I and II (circle one)
- d. More like II than I
- e. Just like II

Statement II - The team's basic overall objectives are very clear to me. All of my and everyone else's effort seems directly related to getting these key goals accomplished. Whenever a question arises over what things need to get done we are able to set priorities by referring back to our basic objectives.

2. Statement I - Often situations arise on the job where I'm not certain what I am supposed to do. Frequently, I'm not even sure if a situation is my responsibility or someone else's. We never get together to discuss what each individual thinks he (she) and the others on the job can or should do to work together to do the best job.

- a. Just like I
- b. More like I than II
- c. In between I and II (circle one)
- d. More like II than I
- e. Just like II

Statement II - In almost every situation I am very sure about what responsibilities I have and about what others on the job are supposed to be doing. These job responsibilities are often discussed by relevant members of the team, particularly when someone has a question about what he or someone else should be doing.



3. Statement I - Different people on the job are always asking me to do different things at the same time. Often these tasks get in the way of each other or there just isn't enough time to meet everyone's demands. My job makes me feel like a "juggler with too many balls."

- a. Just like I
- b. More like I than II
- c. In between I and II (circle one)
- d. More like II than I
- e. Just like II

Statement II - I have no trouble in doing the different things that the job and other people on the team require of me. I understand why I'm supposed to do the things I do and it all seems to fit together. If I feel as though the demands people on the team make of me are getting too heavy or don't make sense, we resolve the problem with a discussion.

4. Statement I - When some people try to participate in a discussion of job issues, they often get cut off or their suggestions seem to die. People only seem to pay attention to some team members and not others. Some people seem to do most of the talking while others don't participate very much.

- a. Just like I
- b. More like I than II
- c. In between I and II (circle one)
- d. More like II than I
- e. Just like II

Statement II - Everyone gets a chance to express himself and to influence the group in discussions about the job. We listen to every person's contributions and try to discuss the strong points in each. No one is ignored. Everyone is drawn into the discussion.

5. Statement I - When we sit down to discuss something I usually walk away wondering what we just did and what is supposed to happen next. If, as a result of a discussion, I am assigned to do something, I often do not agree with the tasks assigned me. It seems like the same problems keep coming up for discussion even though we thought we had worked them through already.

- a. Just like I
- b. More like I than II
- c. In between I and II (circle one)
- d. More like II than I
- e. Just like II

Statement II - When we have a problem to discuss, I usually understand exactly what the issue is. By the end of the discussion, I usually understand what we have decided to do about it, and what my responsibilities are. Decisions made by this team are carried out effectively by the team members.

DIRECTIONS

This scale is different from the previous ones. In this scale, read all the statements and circle the letter next to the one statement that most closely describes the general situation in your team.

6. When a disagreement arises in the team:
- a. We assume it's probably best not to let it get personal so we let it pass hoping it will cool down and eventually be forgotten. If it does start to ruffle feelings, we try to smooth the feelings and make the least of the disagreements (e.g. "...well, there is really no point in fighting about it--so, let's forget it" or "we're all grown-ups, we shouldn't argue.").
  - b. Often we end the disagreement when someone on the team takes charge and makes a decision, or decides not to discuss it any further.
  - c. We try to come to an agreement somewhere between the two disagreeing positions. In other words, we compromise. That way everyone gets a little and everyone gives a little and the disagreement is taken care of.
  - d. We get the disagreeing parties together and have them talk to each other about their points of view until each party can see some logic in the other's ideas. Then we try to come to an agreement that makes sense to everyone.
7. Statement I - I often get the feeling that some people on the team don't think that some other people on the team have much of a contribution to make. Some people don't pay much attention to the problems or suggestions of others. People are often taken for granted.
- a. Just like I
  - b. More like I than II
  - c. In between I and II (circle one)
  - d. More like II than I
  - e. Just like II

Statement II - Everyone recognizes that the job could not be done without the cooperation and contribution of everyone else. Each person, including myself, is treated as an important part of the team. When you bring up an ideas or a problem, people sit up and take notice. It makes you feel that you and your job are important.

8. Statement I - This job really gets me down. People do not seem concerned with helping each other get the job done. Everyone is pulling in opposite directions, everyone is out for himself. If you try to do something different, you get

jumped on by people for being out-of-line, or if you make a mistake, you never hear the end of it.

- a. Just like I
- b. More like I than II
- c. In between I and II (circle one)
- d. More like II than I
- e. Just like II

Statement II - I really like my job, and I like working with this team. The team encourages you to take responsibility. You feel really appreciated by the other members of the team when you do a good job. When things aren't going well, people really make an effort to help each other. We really pull together on this team.

APPENDIX "D"

CHILD DEVELOPMENT CLINIC

PATIENT RECORD

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_ HOSP# \_\_\_\_\_

INTAKE PERSON \_\_\_\_\_ DATE \_\_\_\_\_

REFERRED BY:   
 1. Physician \_\_\_\_\_   
 2. Agency \_\_\_\_\_   
 3. Other \_\_\_\_\_

Check <input checked="" type="checkbox"/>	REFERRING PROBLEM	DIAGNOSIS
1.	_____	1. Behaviour problem
2.	_____	2. Communication problem
3.	_____	3. Developmental problem
4.	_____	4. Kindergarten or school performance problem
5.	_____	5. Custody problem
6.	_____	6. Adoption or foster home problem
7.	_____	7. Research
8.	_____	8. Other

WORKING DIAGNOSIS in detail: \_\_\_\_\_

DISPOSAL and FOLLOW-UP

1. Internal Referral (circle)    S.W.    N. School    Psych.    Speech    Hearing    Ped.

2. Follow-up <u>appt.</u>	S.W.	N/S	Psych.	Sp.	Hearing	Ped.
Date -	_____	_____	_____	_____	_____	_____
-	_____	_____	_____	_____	_____	_____
-	_____	_____	_____	_____	_____	_____
-	_____	_____	_____	_____	_____	_____
-	_____	_____	_____	_____	_____	_____
-	_____	_____	_____	_____	_____	_____
-	_____	_____	_____	_____	_____	_____

Kept    
 Kept

3. Agency Referral - \_\_\_\_\_

4. Discharged - \_\_\_\_\_

\* First sheet filed - diagnosis   
 Second sheet in chart

APPENDIX "B"

SUPPLEMENT TO PATIENT RECORD

Addendum to Question 1

I(a) Internal Referrals:

Purpose of Referral: (Please identify a reason for each referral made.)

- 1. \_\_\_\_\_  
\_\_\_\_\_
- 2. \_\_\_\_\_  
\_\_\_\_\_
- 3. \_\_\_\_\_  
\_\_\_\_\_
- 4. \_\_\_\_\_  
\_\_\_\_\_

II. Goal Setting: Please be as specific as possible, ie., rather than defining "assessment" as a goal, please cite the ultimate objective for doing the assessment or the interview. Eg., Determine family dynamics; determine methods for increasing family support of treatment plans, etc.

- 1. \_\_\_\_\_  
\_\_\_\_\_
- 2. \_\_\_\_\_  
\_\_\_\_\_
- 3. \_\_\_\_\_  
\_\_\_\_\_

III. Goal Settings: Who was involved in setting each goal? (Please be specific)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

IV. Family Contacts: Family members (or significant others) contacted by CDC staff.

Please identify by name and relationship to the identified patient.

1. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Method)-see code

Reason contacted:

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Method)

Reason contacted:

\_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Method)

Reason contacted:

\_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Method)

Reason contacted:

\_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Method)

Reason contacted:

\_\_\_\_\_

\_\_\_\_\_

Method Code - Telephone (P)  
 - Written Communication (W)  
 - Personal interview at place of residence or work (I)  
 - Personal interview at CDC (IC)

NOTE: If you need more room for any question, please use the back of this sheet or add a new sheet at the back of these pages.

APPENDIX E  
CLIENT EVALUATION

1. Who referred you to the Child Development Clinic?  
 \_\_\_\_\_  
 \_\_\_\_\_
2. What problem was your child referred for? (Please specify)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 3a. How helpful do you feel that CDC staff has been with your problem?  
 \_\_\_ Very Helpful    \_\_\_ Somewhat Helpful    \_\_\_ Not Sure  
                   \_\_\_ Somewhat Unhelpful    \_\_\_ Very Unhelpful
- 3b. What kind of help have they, or are they, giving you? (Please check as many as apply).  
 \_\_\_ provided information about the problem  
 \_\_\_ gave emotional support to you and/or your child  
 \_\_\_ helped sort out problems with other agencies or professionals  
 \_\_\_ made helpful referrals to other agencies  
 \_\_\_ provided treatment for your child's physical and/or emotional problems  
 \_\_\_ Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 3c. If they have not been very helpful, how could things have been done differently?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Who in your family has been contacted by the CDC? (please check as many as apply).  
       \_\_\_ mother                    \_\_\_ referred child  
       \_\_\_ father                   \_\_\_ others (specify) \_\_\_\_\_  
       \_\_\_ siblings                \_\_\_\_\_  
                                           \_\_\_\_\_
5. Who have they been contacted by? (Please check as many as apply).  
       \_\_\_ Social Worker    \_\_\_ Audiologist  
       \_\_\_ Psychologist    \_\_\_ Speech Therapist  
       \_\_\_ Physician        \_\_\_ Nursery School Teacher  
       \_\_\_ Other (Specify) \_\_\_\_\_  
                                           \_\_\_\_\_

6. Who at CDC has your child talked with about his/her problem?  
(Please check as many as apply).

- Social Worker       Audiologist  
 Psychologist       Speech Therapist  
 Physician       Nursery School Teacher  
 Other (specify) \_\_\_\_\_

7. How well informed has CDC staff kept you about what they are doing or planning to do with your child?

- Very well informed       Somewhat Informed       Not sure  
 Somewhat uninformed       Very uninformed

8. Have you and your child concluded your involvement with CDC?

- (Yes)       (No)

If yes, why?

- Treatment and assessment concluded  
 Dropped out (If you checked this category, please state why (specify):  
 \_\_\_\_\_  
 \_\_\_\_\_

Referred to another agency

Other (specify) \_\_\_\_\_

9. Generally speaking, how satisfied are you with the help you and/or your child is receiving at CDC? (Please check one).

- (a)  Totally satisfied      (b)  Quite satisfied  
 (c)  Neither satisfied nor dissatisfied      (d)  Quite dissatisfied  
 (e)  Totally dissatisfied

10. Are there any suggestions that you wish to make for improving the service provided by the team at CDC? If so, please specify.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Thank you



## APPENDIX F

## COVER LETTER

Dear \_\_\_\_\_:

I am presently involved in a study of the team at the Child Development Centre (CDC) and have been given your name by Dr. K. McRae as the parent(s) of a child who has recently become involved with the Clinic. Although I recognize that your involvement with the Clinic has been limited, I wish to determine how you feel about the care you and your child have received so far.

I hope that you will complete and return the enclosed questionnaire, using the self-addressed, stamped envelope provided. Please feel free to be as open as you can as this information will be kept confidential and will not be shared in any way that will link your name with your comments. This study is of a brief duration, therefore, your early reply will be appreciated.

Thank you for your time and your cooperation.

Sincerely

Ms. S. H. Harrison  
Masters Student  
Faculty of Social Work  
University of Manitoba

SH/pr  
Encl.

## FOLLOW-UP LETTER

Dear \_\_\_\_\_;

I am writing in follow-up to my previous letter and questionnaire about the care you received at the Child Development Clinic. As I noted in my original letter, I am involved in a study of their team. Although I recognize that your involvement with the Clinic has been limited, I would appreciate hearing your comments on the care you and your child have received so far.

I hope that you will be able to complete the questionnaire that was sent to you. Again, let me assure you that your comments shall be kept confidential. As this study is of a brief duration, I would appreciate it if you could return your completed questionnaire to me by May 23, 1980.

Thank-you for your time and co-operation.

Sincerely

Ms. S.H. Harrison  
Masters Student  
Faculty of Social Work  
University of Manitoba

## APPENDIX H

CASES EXCLUDED FROM CLIENT SAMPLE

TABLE 88

PRESENTING PROBLEMS OF CASES EXCLUDED  
FROM CLIENT SAMPLE (seen by one team member)

Type of Case*	Frequency of Occurrence
Behavior Problem	7
Communication Problem	1
Development Problem	2
Kindergarten or school performance problem	3
Custody/Access Problem	-
Adoption/foster home problem	2
Research	-
Other (visual handicap) sleep disturbance	2
Total	17

\* categories developed by C.D.C. and used on their Patient Record  
Sheets (see Appendix D).

Table 88 indicates that those cases which were seen by only one team member fell into most categories of presenting problems. Seven were behavior problems, three were kindergarten or school placement problems, two each were developmental problems, adoption/foster home problems, and other (specifically, one visual handicap and one sleep disturbance), and one was a communication problem.

Table 89 indicates that the casework for five of the seventeen cases had a social focus, <sup>four</sup> ~~three~~ had a physical focus and <sup>four</sup> ~~two~~ had a psychological focus. Social workers, physicians and psychologists all handled cases with a social focus, speech therapists and physicians dealt with cases having a physical focus, but only psychologists dealt with cases with a psychological focus.

TABLE 89

TEAM MEMBER INVOLVEMENT AND FOCUS OF CASEWORK  
IN CASES SEEN BY ONE TEAM MEMBER

Presenting Problem and Frequency of Occurrence	Team Members Involved with Case	Focus of Casework
Behavior Problem		
# of cases		
2	-social worker	-social
1	-pediatrician	-physical
3	-pediatrician	-social
<u>1</u>	-psychologist	-social
Total	<u>7</u>	
Communication Problem		
# of cases		
<u>1</u>	-speech therapist	-physical
Total	<u>1</u>	
Developmental Problem		
# of cases		
<u>2</u>	-physician	-physical
Total	<u>2</u>	
Kindergarten/School Placement Problem		
# of cases		
<u>3</u>	-psychologist	-psychological
Total	<u>3</u>	
Adoption/foster home problem		
# of cases		
1	-psychologist	-psychological
<u>1</u>	-physician	-social
Total	<u>2</u>	
Other		
# of cases		
<u>2</u>	-physician	-social
Total	<u>2</u>	
Total of All Cases		
	<u>17</u>	

## BIBLIOGRAPHY

1. Babbie, Earl R. The Practice of Social Research, Belmont: Wadsworth Publishing Company, Inc., 1975.
2. Bass, Bernard M. Leadership, Psychology, and Organizational Behavior New York: Harper & Brothers, 1960.
3. Beal, George M., Bohlen, Joe M., and Raudabaugh, N. Neil. Leadership and Dynamic Group Action. Ames: The Iowa State University Press, 1962.
4. Beckhard, Richard 1972. "Organizational Issues in the Team Delivery of Comprehensive Health Care", The Milbank Memorial Fund Quarterly. p. 97 - 126.
5. Bell, A; Lowe, Sandra; Keith, Dorothy; McRae, K. N.; Grant, W. Wallace "The Child Development Clinic of the Children's Hospital and Its Method of Collaborative Treatment", The Journal - Lancet. Feb. 1967 Vol. 87. No. 2. p. 68.
6. Bennis, W. G. "Revisionist Theory of Leadership", Harvard Business Review. 39. 1961.  
  
Beyond Bureaucracy: Essays on the Development and Evolution of Human Organization. New York: McGraw-Hill Book Company, 1966.  
  
Organization Development: Its Nature, Origins, and Prospects. London: Addison-Wesley Publishing Company, 1969.
7. Bernard, S. E. and Ishyama, T. "Authority Conflicts in the Structure of Psychiatric Teams", Social Work, 5, (1960) p. 77-83.
8. Bernstein, S. Exploration in Group Work. Boston: Boston University School of Social Work, 1965.
9. Brieland, Donald; Briggs, Thomas L.; Luenberger, Paul. The Team Model of Social Work Practice. Syracuse: Manpower Monograph, 1973.
10. Briggs, Thomas L. "Human Service Teams: Past, Present and Future", Statewide Career Planning in a Human Service Industry. Edited by Michael Austin and Philip L. Smith. Tallahassee: State University System of Florida. 1973.
11. Brill, Naomi. Teamwork: Working Together in the Human Services. New York: J. B. Lippincott Company, 1976.
12. Brinkerhoff, Merlin B. and Kunz, Philip R., Complex Organizations and their Environments. Dubuque, Iowa: Wm. C. Brown Company Publishers. 1972.
13. Briscoe, Catherine, and Thomas, David N. Community Work: Learning and Supervision. London: George Allen and Unwin Ltd. 1977.

14. Brock, Margaret Gaughan. Social Work in the Hospital Organization. Toronto: University of Toronto Press, 1969.
15. Brown, J. Douglas. The Human Nature of Organizations. New York: American Management Association. 1973.
16. Burns, James McGregor. Leadership. New York: Harper & Row Publishers, 1978.
17. Butrym, Zofia. Social Work in Medical Care. New York: Humanities Press, 1967.
18. Connery, Maurice. "The Climate of Effective Teamwork", Journal of Psychiatric Social Work. Vol. XXII (1) Oct. 1952.
19. Drew, Jr., Arthur L. "Teamwork and Total Patient Care", Journal of Psychiatric Social Work, XXII, Oct. 1953, p. 25-31.
20. Fiedler, Fred E. Leader Attitudes and Group Effectiveness. Illinois: University of Illinois Press. 1958.
21. Fisher, B. Aubrey. Small Group Decision-Making: Communication and the Group Process. New York: McGraw-Hill Book Company. 1974.
22. French, Ruth M. The Dynamics of Health Care. New York: McGraw-Hill Book Company, 1974.
23. Gay, Keith E. "The Health Team in Family Practice", Canadian Journal of Public Health. (62) March - April 1971. p. 101 - 104.
24. George, Madelon; Ide, Kazuyoshi; Vambery, Clara E. "The Comprehensive Health Team: A Conceptual Model", Journal of Nursing Administration. March - April 1971. p. 9 - 13.
25. Gil, D. "Social Work Teams - A Device for Increased Utilization of Available Professionally Educated Social Welfare Personnel," Child Welfare. 44 (1965) p. 442 - 446.
26. Goldstein, Harris K. Research Standards and Methods for Social Workers. Northbrook: Whitehall Company. 1969.
27. Grant, W. Wallace. "A Pre-school child Development Clinic", Canadian Psychiatric Association Journal. Vol. 8. No. 2 April 1963.
28. Grieff, Shirley A. "Role Relationships Between Nonphysician Treatment Team Leaders and Team Psychiatrists", Community Mental Health Journal, 9 (4) 1973, p. 378-387.
29. Hall, J. "Decisions, decisions, decisions," Psychology Today. 1971. 5, p. 51.
30. Hiltner, Seward. "Tension and Mutual Support Among the Helping Professions", Social Service Review. Vol. 30-31 1956-57 p. 377-389.

31. Horwitz, John J. Team Practice and the Specialist. Springfield: Charles C. Thomas Publisher, 1970.  
 — "Interprofessional Team Work", The Social Worker, 38 (1) p. 5-10. 1970.
32. Jay, Antony. "Corporation Man". Intellectual Digest. 1972. p. 69-76.
33. Jun, Jong S. Management by Objectives in Government: Theory and Practice. Beverly Hills: Sage Publications, Inc. 1976.
34. Kane, Rosalie A. Interprofessional Teamwork. Syracuse: Manpower Monograph, 1975.  
 — "The Interprofessional Team as a Small Group," Social Work in Health Care. (1) p. 19-32.
35. Koop, Neil. Multi-Service Delivery Systems in the Human Services. Practicum Report - Unpublished. 1977.
36. Knutson, Andie, L. The Individual Society and Health Behavior. Russell Sage Foundation. New York. 1965.
37. Leininger, Madeline. Health Care Issues. Philadelphia: F. A. Davis Company. 1974.
38. Lewis, Jerry M. "The Organizational Structure of the Therapeutic Team", Hospital and Community Psychiatry, July 1969. p. 36.
39. Loeb, Eleanor. "Some Concepts of Interdisciplinary Practice". Social Work (Oct. 1960)
40. Lofland, John. Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. Belmont: Wadsworth Publishing Company, Inc. 1971.
41. Luszki, Margaret Barron. Interdisciplinary Team Research Methods and Problems. New York: New York University Press. 1958.
42. McMurray, Robert N. "The Case for Benevolent Autocracy", Harvard Business Review. Jan.-Feb. (36) 1958.
43. Mechanic, David. Mental Health and Social Policy. New Jersey: Prentice-Hall, Inc. 1969.
44. Mira, Mary P. "One Team's Record: An Analysis of the Behavior of a Professional Group", Social Science and Medicine. April 1969. Vol. 3. No. 1. p. 95-100.
45. Monograph II: Social Work Practice in Medical Care and Rehabilitation Settings: Teamwork: Philosophy and Principles. Washington, D.C. July 1955.

46. Neubauer, Peter B.; Steinert, Joseph. "The Significance for Social Workers of the Multidisciplinary Approach to Child Development", Social Service Review. 1950 (24) p. 459-468.
47. New, Peter, Kong-Ming. "An Analysis of the Concept of Team Work", Community Mental Health Journal. 1968 (4) p. 326-339.
48. Olmsted, Barney. "Job Sharing - A New Way to Work", Personnel Journal, Feb. 1977 Vol. 56, (2) p. 78-81.
- "Job Sharing; an Emerging Work Style". International Labour Review. Vol. 118 No. 3 May - June 1979. p. 283-297.
49. Olsen, Katherine M. and Olsen, Marvin E. "Role Expectations and Perceptions for Social Workers in Medical Settings", Social Work. (12) 1967 p. 70-78.
50. Oppenheim, A. N. Questionnaire Design and Attitude Measurement. New York: Basic Books Inc. 1966.
51. Parker, Albert A. The Team Approach to Primary Health Care. Berkley: University of California. 1972.
52. Patton, Bobby R.; Giffin, Kim. Problem-Solving Group Interaction. New York: Harper & Row, Publishers 1973.
53. Perrow, Charles. Complex Organizations: A Critical Essay, Glenview, Illinois: Scott, Foresman and Company, 1972.
54. Potter, Thelma I. "The Health-Team Approach to Total Patient Care", Hospital Administration in Canada. Nov. 1969. Vol. II. No. II. p. 53-56.
55. Pringle, Bob. Interprofessional Teamwork In the Human Services. Unpublished Practicum Report. 1978.
56. Rappaport, Julian. Community Psychology Values, Research and Action, New York: Holt, Rinehart and Winston. 1976.
57. Raven, B. H., and Rietsema, J. "The Effects of Varied Clarity of Group Goal and Group Path, on the Individual and His Relation to the Groups." Group Dynamics. Ed. by Dorwin Cartwright and Alvin Zander. London: Tavistock. 1966.
58. Rehr, Helen. Medicine and Social Work: An Exploration in Inter-professionalism. New York: Prodist, 1974.
59. Robinson, Dorothy. "Some Aspects of the Integrative Process in a Psychiatric Setting," Journal of Psychiatric Social Work, XXIII (Oct. 1953) p. 31-36.
60. Rubin, Irwin M., and Beckhard, Richard. Factors Influencing the Effectiveness of Health Teams. The Milbank Memorial Fund Quarterly. 1972. p. 311-329.



61. Rubin, Irwin M., Plovnick, Mark S., and Fry, Ronald E. Improving Co-ordination of Care: A Program for Health Team Development. Cambridge: Ballinger Publishing Company, 1975.
62. Schein, E. H. Process Consultation. Reading, Mass: Addison-Wesley. 1969.
63. Scott, W. Richard. "Some Implications of Organizational Theory for Research of Health Services", Milbank Memorial Fund Quarterly. New York: Rodist, 1974. p. 3-27.
64. Selltitz, Claire; Jahoda, Marie; Deutsch, Morton; Cook, Stuart W. Research Methods in Social Relations. New York: Henry, Holt, and Company, Inc. 1959.
65. Sherif, Muzafer and Sherif, Carolyn W. Interdisciplinary Relationships in the Social Sciences. Chicago: Aldine Publishing Company. 1969.
66. Stuecks, A. "Working Together Collaboratively with other Professions," Community Mental Health Journal, 1965 (1) p. 316-319.
67. Szasz, George. "Education for the Health Team", Canadian Journal of Public Health. Vol. 61 Sept./Oct. 1970. p. 386-390.
68. The Welfare Council of Greater Winnipeg. Psychiatric Services Study. 1956.
69. Thelan, H. A. Dynamics of Groups at Work. Chicago: University of Chicago Press. 1954.
70. Tripodi, Tony; Fellin, Phillip; and Meyer, Henry J. The Assessment of Social Research. Itasca: F. E. Peacock Publishers, Inc. 1969.
71. Trute, Barry. A Model for the Evaluation of Community Health Centres: The Churchill System. Ottawa: Evaluation Research Training Institute. 1977.
72. Valletutti, Peter and Christoplos, Florence (ed.) Interdisciplinary Approaches to Human Services. Baltimore: University Park Press. 1977.
73. Watt, Susan. "The Modified Lateral Team in a Psychiatric Setting", The Social Worker 41 (1) Spring, 1973.
74. Wise, Harold; Beckhard, Richard; Rubin, Irwin, and Kyle, Aileen. Making Health Teams Work. Cambridge: Balinger Publishing Company, 1974.
75. Zander, Alvin; Cohen, Arthur R., and Stotland, Ezra. Role Relations in the Mental Health Professions. Ann Arbor: University of Michigan, 1957.
76. Zax, Melvin; Cowen, Emory L. Abnormal Psychology: Changing Conceptions. New York: Holt, Rinehart and Winston. 1976. p. 59-81.