

Leading and working in teams

This article considers the role of the clinical leader as a team member and leader and explores how an understanding of the purpose and functions of teams can help doctors work more effectively in the various teams with which they are involved.

Health care is primarily delivered by a range of health workers and managers working in a number of interlinked teams. Effective teamwork is increasingly important for a number of reasons:

- The complexity and specialization of care
- Ageing populations with comorbidities and rise of long-term conditions
- Global workforce shortages
- Changes in skills mix of health workers
- Safe working hours' initiatives
- Shifts towards more integrated health and public services.

'Our challenge is not whether we will deliver in teams, but rather how well we deliver in teams' (Schvye, 2005). Given the importance of teams to the delivery of effective health care, clinical leaders need to be able to lead, work within and between teams as seamlessly as possible. Understanding what makes teams function well and less effectively can help leaders overcome some of these team-working challenges. The teamSTEPPS programme identifies different, inter-related team types that support and deliver health care:

1. Core teams – involved in direct patient care, usually (but not always) based where the patient receives care
2. Coordinating teams – responsible for operational and resource management and allocation
3. Contingency teams – emergent, crisis, time-limited, formed from various core team members
4. Ancillary and support services – service delivery, e.g. cleaners, porters, catering, medical records
5. Administration – executive leadership, define culture, policies, staff expectations (Agency for Healthcare Research and Quality, 2008).

Drivers for improved teamworking and leadership in health care

Whether as components of clinical competence and communication skills, commitment to professional

competence or working in partnership, effective leadership and teamwork are increasingly recognized as essential skills in clinical care (e.g. Francis, 2013). In the UK, the National Confidential Enquiry into Maternal Deaths stated that poor teamwork was a leading cause of substandard obstetric care (Cooper and McClure, 2005). In the US, the Institute of Medicine's (2001) report *Crossing the Quality Chasm* emphasized the need for improved leadership and teamwork in clinical practice, as discussed by Chakraborti et al (2008). Hjortdahl et al (2009) suggested that effective leadership improves team performance and goal achievement and other research has shown that good teamwork reduces errors, reduces mortality and morbidity rates and improves patient safety (Neily et al, 2010). From a social perspective, as the population ages, more patients will present with multiple health problems, requiring effective interdisciplinary teamwork and leadership (Xyrichis and Ream, 2008).

Since 2009, a number of high-profile inquiries into poor health care have made clear links between leadership, multidisciplinary teamwork, high quality health care and good health outcomes. The Francis (2013) report detailed the failings in care at the Mid-Staffordshire NHS trust. Poor leadership by nursing, medical and boardroom staff was highlighted as a particular area of concern. It also called for 'effective teamwork between all the different disciplines and services'. The report emphasized the importance of good leadership:

'The common culture and values of the NHS must be applied at all levels of the organization, but of particular importance is the example set by leaders' (Francis, 2013).

The Keogh review (Keogh, 2013) subsequently reported on 14 hospitals with high standardized mortality ratios. Poor leadership was again identified as a cause of patient harm. The Prime Minister then asked Don Berwick, former president of the US Institute for Healthcare Improvement, to report on patient safety. His report *A promise to learn: a commitment to act. Improving the Safety of Patients in England* (National Advisory Group on the Safety of Patients in England, 2013) recommended that 'All NHS leaders and managers should actively address poor teamwork' and gave guidance on the shift in leadership behaviours required.

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Leading and building a health-care team

Ezziane et al (2012) suggested that the key areas for consideration when leading or building a health-care team are communication, decision making, patient safety, conflict resolution and identifying appropriate roles for individual team members.

Communication

As noted above, adverse events resulting from error happen at unacceptably high rates in the inpatient setting, with ineffective or insufficient communication among team members being a contributing factor. Communication through means such as e-mail has increased in the last 10 years, removing several important aspects of interaction, potentially fragmenting and isolating health-care workers, rather than encouraging team-building. Clinical leaders must therefore look for appropriate methods of communication to better direct their teams. Regular meetings that create an environment that welcomes independent expression of a team member's views are particularly important (Ezziane et al, 2012).

Tools that help team members communicate include SBAR (situation, background, assessment, recommendation), callout, check-back and handover or handoff (e.g. 'I pass the baton' – Introduction, Patient, Assessment, Situation, Safety concerns, Background, Actions, Timing, Ownership, Next) (World Health Organization, 2011).

Decision making

In a group or team setting, a leader has to be aware of the tendency for 'group think' where members of the team go along with decisions for fear of being ostracised for challenging a decision. This is linked to the issues of leadership and hierarchy discussed in the section on 'power distance' below. Leaders of a health-care team need to find a leadership style that encourages challenge and nurtures independent thought.

Patient safety

Patient safety is a key focus of improving health care in the UK (Institute for Healthcare Improvement, 2015). Health-care teams have learned from other sectors such as the aviation industry in procedural and mechanised ways of cutting down on errors. Setting clear goals around patient safety and quality improvement helps to focus team members' activities towards a patient-centred approach to care.

Conflict resolution

One of the downsides of precluding group think from a team is a potential increase in conflict. Following disagreement there is potential for confrontation and escalation to occur, which can create long-term disharmony in teams. It is therefore important that a clinical leader is able to foster negotiation and compromise in such situations, more specifically aiming towards group-trust, shared commitments and mutual respect of opposing views (Ezziane et al, 2012).

The World Health Organization (2011) patient safety guide describes three useful tools to help empower team members:

1. The 'two-challenge rule' (voicing and restating concerns at least twice)
2. CUS (I am Concerned, I am Uncomfortable, this is a Safety issue), a three-step process for assisting people in stopping an activity
3. DESC script (Describe the specific situation, behaviour or issue, Express how the situation makes you feel, Suggest other alternatives, state the Consequence) for resolving conflict.

Identifying appropriate roles

Porter-O'Grady (2010) suggests that failure of role assignment to team members is one of the most significant causes of stress in the workplace. Several methods and types of analysis can be used to ensure that there is clarity of role and purpose in the team.

The above points are reinforced by West et al (2015) in their review of the evidence base for leadership in health care. Specifically referring to teamworking and leadership, they note that:

- Effective teamworking is essential for organizational success
 - 'Leadership clarity is associated with clear team objectives, high levels of participation, commitment to excellence and support for innovation'
 - Conflict within teams leads to poor outcomes and processes
 - Shared leadership is a predictor of team effectiveness.
- Specifically we should ask: What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement? (Institute for Healthcare Improvement, 2015).

West and Lyubovnikova (2013) suggest that teams which have low levels of interdependence, shared objectives and reflectivity are known as 'pseudo-teams' – while they may appear team-like, they have few of the characteristics of effective, high performing teams. The detrimental impact of such pseudo-teams is compounded in that most health professionals work in many teams in different contexts and over time (O'Leary et al, 2011). Being able to work in multiple teams therefore requires an adaptive mix of flexibility, credibility and authenticity, and leaders need also to be able to effect communication and manage activities between teams.

Multi-professional teams

As services become more integrated and person-centred, health workers are increasingly working in multi-professional teams. Multi-professional teamworking can be defined as:

'A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and

exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organisational and staff outcomes.' (Xyrichis and Ream, 2008)

Whatever the makeup of the team, research has shown that the quality of leadership is crucial to improved outcomes for patients and that an engaging, authentic and shared leadership approach is the most effective (West et al, 2015). While leading or working within uni-professional teams can be very challenging, additional and specific challenges exist when working in multi-professional teams.

First, multi-professional teams tend to have complex structures. While uni-professional teams usually have a single reporting line, multi-professional teams often have more complex structures – perhaps reporting to different senior managers, and having separate supervisory and, often, funding arrangements. Second, multi-professional teams include a range of different professionals. The leader typically comes from a background in one profession and he/she will have to gain the respect of the full range of professions within the team. Acknowledging and working with potential issues of authority, power and control and resolving conflicts are essential skills for team leaders (Barrow et al, 2104). Leaders who can work adaptively within such complexity are likely to be more successful.

It is vital that leaders establish and maintain credibility but this can be difficult when they are responsible for other professionals, clinical practice or activities which did not form part of their education or training. Working with, motivating, leading and supervising people with a range of values and skills bases raises issues about 'professional identity' (Anning et al, 2010). Professional identity (the values and scope of practice that defines a profession) can be very positive, it binds people together and helps them feel that they belong to a community of practice. However, because each professional identity requires people to see members of professions different from theirs as 'the other', this can lead to 'in groups', 'out groups', misunderstandings and miscommunications. Leaders who understand this and can negotiate and agree common values, goals and approaches to care will help bring team members together around a shared purpose and way of working, despite their professional backgrounds.

Leaders of multi-professional teams also need to be 'boundary crossers' (Mathur and Skelcher, 2007), i.e. have the ability to work with a range of professional groups in a way that engenders confidence. They will need to take a 'translational' role, learn to speak the 'language' of different professional groups (including health managers) and demonstrate respect for all team members' perspectives. A distributed or shared leadership style will be a good fit in most contexts and the leader will need to strike a balance between maintaining an authoritative

and confidence-inspiring leadership style and being able to admit when he/she does not have sufficient knowledge about a profession to make a decision.

Teamworking and power relations

Barriers to effective teamworking include changing roles, changing settings, medical hierarchies, individualistic nature of medicine and instability of teams (World Health Organization, 2011). In medicine, physicians have traditionally been at the top of the power structure and, consequently, have the greatest potential to impact those around them, including patients and other members of the health-care team. This phenomenon is commonly referred to as 'power distance.' Power distance occurs when individuals in positions of less power are reluctant to challenge those with greater authority and can lead to detrimental outcomes for patients and unhelpful ways of working such as sabotage, working around and passive aggression or rebellion (Barrow et al, 2014).

In some environments, such as the battlefield or emergency situations, strict adherence to the established power structures is vital but in other contexts, power distance may actually result in harm. The power distance index was part of Hofstede et al's (2010) cultural dimensions theory which given insight into the impact of cultural difference and leadership in global business. Using a low power distance management or negotiation approach (i.e. engaging or nearby leadership) with someone accustomed to a high power distance culture may be counter-productive and vice versa. Power distance may also describe the leadership relationship between doctors and other health-care professionals, especially nurses.

While leader–follower relationships involve dominance and some deference, this can be catastrophic in consequence when people feel they cannot speak out. The airline industry has many examples of where the hierarchical nature of the leadership among the crew resulted in catastrophe, for example the crash of Korean Air Flight 801 in 1997 was attributed primarily to the rigidly hierarchical power structure in the cockpit, which prevented crew from speaking up until it was too late. In medicine, lack of clarity in the leadership structure and inability to challenge the leadership decisions of others can be equally catastrophic. In March 2005, Elaine Bromiley, a 37-year-old mother of two, was scheduled to undergo a routine sinus operation under general anaesthesia. Unfortunately there were complications with managing her airway after she had been anaesthetized. Two consultant anaesthetists and a consultant ear, nose and throat surgeon were unable to obtain a definitive airway and she suffered hypoxic brain damage. Her life support was switched off some days later. An independent report into her death criticized the lack of communication within the team (Harmer, 2007). Her husband, Martin Bromiley, an airline pilot and expert in human factors training in aviation, stated:

‘The lead anaesthetist... in his own words “lost control”. There was a question mark, in the inquest, about who people felt was in charge at different points... There was certainly a breakdown in the decision-making processes and it would appear that the communication processes dried up amongst the consultants.’ (Clinical Human Factors Group, 2008)

In a study, medical students were placed in a simulated acute situation as part of their course on leadership and professionalism. A sample of the students were placed in a situation where a senior colleague made a deliberate and potentially life-threatening error. Where students did not challenge the senior colleague, the most common reason for not speaking up was ‘assumed hierarchy’, i.e. the senior is not questioned simply because he/she is more senior, rather than perceived to be more experienced (the second most common reason for not speaking up) (Money Penny et al, 2013). In a similar simulator-based study, St Pierre et al (2012) looked at the willingness of residents and nursing staff to challenge deliberate errors committed by attending physicians. They found that the attending was only challenged in 28% of situations. When they did challenge they used crisp advocacy-inquiry (40%), an oblique statement (35%) or addressed the problem without pursuing it further (25%). When asked why they did not challenge, 37% had no answer, 35% admitted to there being a discrepancy between what they knew and what they did, 12% explained that the authority gradient prevented them from speaking up, while 8% stated that attendings routinely violated standard operating procedures without being challenged.

Responses to adverse events and reports on teamworking routinely emphasize the need to move away from a hierarchical, ‘command and control’ leadership style to one of distributed, shared, collaborative or collective leadership. The evidence that this type of team and organizational leadership impacts positively on health outcomes, the patient experience and staff morale is growing (West et al, 2015). The strong focus on quality improvement and patient safety philosophies drawn largely from non-health care safety-critical industries (such as aviation and nuclear power) underpins health professionals’ leadership and teamwork, all of which aligns with a change in culture that promotes patient-centredness and high quality, safe, compassionate care (Francis, 2013). A key challenge that remains for leaders is to facilitate, support and empower individuals and groups to speak out and act when they see poor or unsafe health care.

Teaching and assessing teamwork

Professional standards, frameworks and guidance exist to help practising doctors, educators and learners to work out what knowledge, skills and behaviours are required to work in and lead teams effectively. In 2012, the UK General Medical Council published *Leadership and man-*

agement for all doctors outlining standards expected of doctors (General Medical Council, 2012). This makes it clear that effective teamworking and leadership is a professional obligation, expected of all doctors. In the UK, the Healthcare Leadership Model has been introduced which aims to help professionalise leadership at all levels of health care through defining expected leadership behaviours (NHS Leadership Academy, 2013). Such frameworks and standards help educators and learners to define what is expected from them. The Faculty of Medical Leadership and Management was established in 2011 to ‘promote the advancement of medical leadership, management and quality improvement at all stages of the medical career’ (Faculty of Medical Leadership and Management, 2014). Membership provides access to events, expertise, coaching and mentoring support and a range of resources on leadership and management. In 2015, the Faculty of Medical Leadership and Management leadership and management standards for medical professionals were launched, again to help medical leaders and managers to benchmark themselves against best practice.

Worldwide, there has been an increase in defined leadership curricula and the provision of training in non-technical skills, professionalism, teamwork and leadership at all levels (O’Sullivan and McKimm, 2011). Teamwork and leadership have most commonly been subsumed under the banner of professionalism or non-technical skills in both undergraduate and postgraduate training. A number of teaching, learning and assessment methods have been developed to assist with these challenging educational aspects and evidence is emerging as to their effectiveness. In classroom-based situations, facilitating learners to work in multiple teams with directed reflection and to engage in team building exercises can be beneficial, even before they are working clinically. Structured observation of clinical and other teams can also help provide insight into how teams work in practice, supported by presentations around teamworking, who works in teams and by consideration of patient safety issues when teams go wrong. For example, the objective structured teaching exercise has been developed to help faculty teach professionalism in clinical settings (Lu et al, 2014). Acquiring, practising and obtaining feedback on teamworking and leadership skills in a longitudinal developmental way is best undertaken through workplace-based learning and assessment, including multi-source feedback, e.g. the team assessment of behaviour assessment in the foundation programme. Structured portfolios, which combine practical assessment with reflection, can help support long-term teamworking and leadership development.

Written tests include prioritisation tests and situational judgement tests and while these can be helpful to provide a point in time assessment, unless they form part of a programmatic assessment, they do not aid long-term practice development. Simulation provides many opportunities for practising skills and obtaining feedback on

teamworking, from simple role play to engagement in high fidelity scenarios. For example, the University of Dundee has developed a postgraduate ward simulation exercise which assesses teamwork and leadership skills such as the 'ability to prioritise competing demands, make safe informed decisions, prescribe safely and manage the care of three patients' (Stirling et al, 2012).

Khan et al (2011) argue that the realistic simulated environment improves memory recall and application of this information. This supports the use of simulation-based assessment in terms of its catalytic effect on promoting positive behavioural change (Norcini et al, 2011). In addition, the simulated environment may provide the opportunity for learning in action, which appears to be a more effective learning method (O'Sullivan et al, 2012). In their study with medical undergraduates, Paskins and Peile (2010) found that students thought the use of mannequin-based simulation allowed them to develop teamwork skills not only as a more efficient team member but also as a leader. This finding supports the use of simulation to assess teamwork and leadership. The authors also found that students exposed to simulation were more confident in their clinical attachments and that they valued both repeated exposure and the feedback on their performance. Khan et al (2011) also argue for the use of simulation in the longitudinal assessment of performance, helping 'to bridge the gap between the classrooms and the clinical environments'.

Conclusions

Being able to work effectively in and lead teams as required is a vital skill for any health professional because effective teams form the cornerstone of high quality health care and contribute to health improvement and patient safety. Much research evidence shows that high performing teams have clear shared goals, clarity of leadership that is authentic and distributed throughout the team, creative (not destructive) conflict and effective communication. Team leaders and members treat one another with respect and mutual trust, they know their strengths and roles, and power, authority and control are not allowed to become issues. Team members are empowered

to challenge if they feel patient safety or care is at risk. The challenge for leaders is to create and maintain this culture across and between multiple teams in what are often very complex and rapidly changing contexts. **BJHM**

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KEY POINTS

- The ability to work within and between teams is a core leadership skill.
- Effective multidisciplinary teamwork contributes to improved health outcomes and a higher quality of care.
- Effective teams need clear goals, shared leadership and ongoing review of performance.
- Leaders need to be aware of power distance, authority and control mechanisms which can undermine effective teamworking.
- Many teams operate dysfunctionally – 'pseudoteams' have few of the characteristics of successful teams, i.e. interdependency, reflexivity and shared objectives.

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