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THE EDUCATION OF THE HEALTH CARE TEAM

WHAT'S IT ALL ABOUT?*

by

Richard Beckhard

May, 1974 WP #709-74

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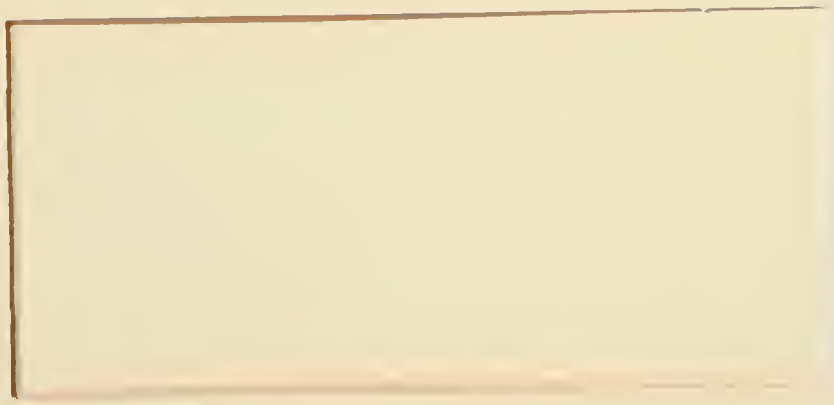

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CONGRESS ON MEDICAL EDUCATION

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"The Education of the Health Care Team"

"WHAT'S IT ALL ABOUT?"

Understanding the Problem

The fact that at a Congress such as this, the topic of "The Education of the Health Care Team" starts with the question "What's It All About?" is indicative, in my opinion, of the vast amount of confusion, differing priorities, biases, and complexities around the whole issue of inter-disciplinary, health-team delivery of care. I suspect that this audience represents a wide range of attitudes toward the subject. In taking the assignment of talking on this question, I am painfully reminded of a speaker at another meeting dealing with a similarly complex topic whose opening comment was: "My job for the next few moments is to talk -- yours is to listen. I hope to heaven you don't finish ahead of me."

Let me begin by defining what I see the issue is and is not.

The issue is not whether team delivery of health care is good or bad, needed or not needed. Team delivery of care exists today, in a wide variety of delivery settings from the private physician-nurse team, to the multi-member interdisciplinary teams in community health centers, out-patient clinics and the like.

The issue is whether teams delivering care who have been helped, through education and training to pay conscious and continuing attention to how they function as a team, are more effective delivers of care.

The relevant variables then are more or less effective and the effects of education on effectiveness.

What I would like to do in the next few minutes is to look at what is meant by an effective team; what are some of its characteristics; and what needs to be built in as capabilities among the members of a team if it is to be effective. First, as background, I want to describe briefly some of the conditions around team delivery, particularly of primary care, that are causing more and more people to be interested in developing changes and modifications in health education to deal with these conditions. Next, I would like to develop some working definitions that might help us to think about the subject.

Conditions Today

1. More and more health care, particularly ambulatory, primary, preventive care is being delivered by interdisciplinary groups of health workers.

2. The delivery of any single, coordinated service such as health care by two or more people with different skills, abilities and backgrounds requires communication, coordination, and some common objectives. For a number of reasons, including different professional backgrounds, training, and a lack of common priorities, these requisites are such that numbers of team leaders, health delivery administrators and team members have been looking for training and educational support to help them be better able to function in this new mode.

3. The multiple settings in which primary care is delivered by teams provide possibilities for different treatment methods. For example, should one treat diabetes or hypertension the same way in a ghetto setting, where daily family visits by a health worker are the mode, as one does in a middle-

class suburban community where only occasional visits to the doctor's office are practical? Or, if the focus of care is comprehensive family care, and if the delivery team includes a community-oriented person, a nurse practitioner and a physician, how should the team best allocate the varying resources of its members to optimize the care?[1]

4. The trend toward more patient management of health care involves different skills and relationships than those required for treatment of disease. Health workers are finding a need for additional, specific educational help for members of interdisciplinary health teams who are focusing on more patient-managed health care.

5. With the increased attention at all levels of the health system on primary care, many health schools are developing new curricula that focus on total, family oriented comprehensive care rather than just hospital care. For example, at the Sloan School we are working with two schools of nursing whose curricula are undergoing a major revision from the traditional in-hospital curriculum to a comprehensive, field-oriented curriculum in which the student connects with a patient family in the community, in the hospital, and back into the community.

It has been found that teaching in such a program, using interdisciplinary specialties from the nursing faculty, has not been easy. A number of problems of coordination, trust, communication, and optimizing the team aspects of the teaching have developed. Many of these require the faculty to spend energy learning to develop their capacity to teach in teams.

6. Medical schools and medical centers are increasingly developing programs in community medicine. In addition to issues around structure, power, and decision-making, there are a number of issues concerning the roles of

health workers performing various functions in the center. Many of the community medicine programs require members of a particular service, such as pediatrics or internal medicine, to function as members of delivery teams with health workers of other disciplines. These delivery tasks require the physicians to operate in different ways from those for which they have been trained, or which are appropriate in a hospital setting. These differences and the impact of physician behavior on other health workers require that specific attention be paid to learning to work in this delivery mode.[2]

These are a few of the major environmental conditions that are providing the impetus for an examination of the education of health teams.

Some "Definitions"

There is so much ambiguity and emotion about the subject of educating interdisciplinary health teams, that I thought it might be useful to present a few working definitions on the subject. Since team effectiveness are the two words most bandied about, let's start with those.

1. Team. A team exists when a task or tasks require the interdependence of a group of people with different technical capabilities. In other words, the delivery of the care requires that the different specialties must interact around certain tasks. Managing the care program for the patient being cared for by a health team implies that all members of the team participate in the management process, to illustrate:

The nurse-secretary in the private physician's office must be part of the planning team if the physician is to be able to focus on those aspects of care for which he is uniquely qualified.

Much care is given in settings that do not require teams, although

groups of specialists may be involved. Delivery team refers to the condition where the delivery of care is given by an interdisciplinary group of specialists functioning as one delivery unit. Educational efforts directed at team effectiveness are designed to help get this work done more effectively.

2. Effectiveness. Effectiveness are outcome measures. In terms of interdisciplinary health care, some measures would be related to the quality of care given by members of the team? How was the care perceived by the patients? How much did patients continue to manage their own care? What was the quality of feedback from the patients to the delivery team that allowed the team to correct its strategy?

3. Efficiency. Efficiency is determined by measures of the internal workings of the group. These measures deal primarily with quantifiable facts. For example, how quickly and cost-effectively does the group process patients? How many patients does the team see? What is the average length of waiting time? Although educational activities may appear to focus on efficiency measures, they are usually directed at dealing with conditions in the team that, if corrected, can make a significant output difference. The difficulty of measuring these differences is one of the dilemmas in the entire issue of how much payoff there is in educating interdisciplinary health teams.

4. Education of Health Teams. There are two types of settings in which such activities occur -- delivery and educational.

A. Delivery Settings[3]

1. Ongoing

Educational efforts in this setting tend to be aimed at helping the team improve its ability to manage conflicts created by inter-dependent tasks through:

- clarifying goals and priorities
- improving their information about role expectations and distribution
- improving their decision making
- improving their capacity to manage their group tasks such as team conferences
- improving the communications between their unit and the rest of the delivery system.

2. Start-Up of New Teams

In this setting, educational efforts are designed to help the team to:

- establish goals and priorities
- examine role expectations and conflicts
- develop ground rules for making decisions
- develop ground rules for managing group activities such as meetings
- develop a pattern for relationships with the rest of the system
- develop ground rules vis-a-vis relationships with the patient community

B. Educational Settings

1. Post-Graduate Level (e.g., house staffs)[4]

Here the major focus of educational efforts tends to be on helping the intern or resident to:

- understand and be more aware of himself as a healer
- understand the problems of cross-cultural interactions
- cope with relationship problems that occur among members of his team and between patients and health workers.

2. Health Schools[5]

Here the learning goals include:

- working as a team member
- entering a work setting and negotiating a work role
- coping with problems of professionalism
- developing effective health worker-patient relationships
- learning primary care technology, e.g., problem oriented patient record
- understanding the nature of family.

I hope these few definitions will help us in the subsequent discussion of this topic.

"Effective" Team Delivery of Care

Let me move on to a description of what is frequently seen by advocates of education of health teams as the characteristics of a "well-educated" team.

Let me also say, at this point, that there is very limited, hard evidence that the quality of care, or, the cure rate,is "better" with "educated" versus "untouched" delivery teams. There are some data on efficiency improvement such as numbers of patients seen etc., there are data from health team members that report they see quality improvement. There is almost no reliable data that patients see a marked difference.

However, given that condition, there is a large and growing body of practitioners and health educators who believe that the investment of time and energy in education of health teams is worthwhile as a capital investment in resources.

Some of the reasons for this posture are that, although difficult to measure, the following conditions in teams will lead to more effective care.

1. A team that is operating effectively will have clear goals, clear role expectations, clear and effective problem-solving methods, and methods of managing its own activities such as conferences, meetings, and resource allocations.[6]

2. An effective team has the maximum energy of its members available for its primary task -- patient care. It will spend a minimum amount of energy on its functioning and relationships. Teams that do not have high effectiveness, do not have these processes in order, tend to spend large amounts of energy on their own working methods and relationships to each other and to the institutions.

3. Teams that have worked through their mission, the issues around values -- different training, different priorities -- of their members; the management of their members' different roles; tend to build in better feedback systems and consequently have better information on the effects of their care, which in turn leads to improvement of care. This kind of information is only likely to be shared when there is enough of a trust level, consensus on common goals, and mutual understanding of the need for "team" care of the patient or patient family.[7]

4. If patients are to trust others, in addition to the physician, in coordinating and handling their care, it will be necessary for all other members of the health team to be seen as so closely connected that the care is not viewed as being delegated to the less competent or less professional.[8]

5. Team effectiveness requires effective management of the natural conflicts that exist inside each health worker around working collaboratively with other professionals and other specialties. These conflicts center around professional roles; around what has been learned professionally versus task requirements; around competence in handling new skills. When

these issues are worked through in the team setting, a climate of support often results that allows each member of the team to focus his or her energy on the mission -- patient care -- rather than on maintaining or developing a professional and personal identity.[9]

6. Groups that work interdependently because it is required by their tasks, tend to be high potential learning environments for the individuals in the group.

7. Care given to patients is increasingly given in a family environment. The delivery team is in a real sense a family. It has all the usual problems, parental authority, sibling rivalry, differential learning styles, different career priorities. If a delivery team can look at its own life as an analogue to the patient family, there are a number of corollary benefits or extra bonuses for all the learners.[10]

These then are some of the -- granted, unproved -- normative positions that are causing more people to expand efforts in this type of education.[11]

Let me quickly summarize the points I've made.

1. More primary, ambulatory care is likely to be delivered in some form of delivery team.

2. If the members of these teams have consciously learned how to behave as a team, they are likely to be more effective and to have more energy available for patient care.

3. Educational or learning settings include (a) teams in action, (b) teams starting up, (c) post-graduate situations such as house staff, and (d) health schools. Efforts are increasing to develop courses, curricula, and programs in all four settings.

4. The assumptions behind these efforts are:

a. Operational Assumptions

(1) Effective teams will have more energy for patients.

(2) Effective teams will optimize member resources.

(3) Effective teams will be more trusted by patients.

(4) Effective teams may have synergistic effects.

b. Educational

(1) Individuals need to learn about group processes, decision making, communication, goal setting, roles, conflict management, health worker-patient relationships, as well as clinical content.

(2) It is best if these issues are learned in an inter-disciplinary group, either in actual teams or analogues to a delivery team.

(3) Some clinical content and most team content are most effectively learned in the team setting.

c. Managerial

(1) Effective teams must manage their own functioning and the delivery of care to their patients; the rest of the health system should serve as support to the teams.[12]

(2) Teams should also manage their own learning using their internal resources to teach each other plus additional resources within and outside the system for special educational support.

Some Implications

Finally, I should like to look at some implications and trends.

1. I think we will be seeing increasing changes in both content and methods for teaching primary care.

2. I think we will be seeing more interschool classes with participants from different health schools.

3. I believe there will be considerably more emphasis on primary care in the core curricula of health schools.

4. There are likely to be additional rotations for house staffs to interdisciplinary, primary care teams.

5. There will be further examination of the mode of work in out-patient clinics with the expectation of more team delivery.

6. There might be reorganization of community health centers to include changes in their educational strategies and practices. Much clinical content may be taught to teams.

7. There will be development of new educational materials and programs to facilitate self-development activities in the areas I mentioned.

8. There will be more systematic research on both educational requirements for interdisciplinary health teams and on measurements of the effectiveness of teams.

Here then are some thoughts on "What's It All About?". For the rest of the morning we will be discussing how it works in practice.

REFERENCES

[1]A case in point occurred in the South Bronx where the physician's prescription was to take one pill after every meal, thus assuming the patient would take three pills daily. Only the family health worker on the team knew that this patient only ate twice a day (if that much) and was probably going to give the pills to others in the family to cure "all their ills." See Fry, R., and Lech, B., "An Organization Development Approach Toward Improving the Effectiveness of Neighborhood Health Care Teams," unpublished Masters Thesis, 1972, M.I.T. Sloan School of Management, 50 Memorial Drive, Cambridge, Mass. 02139

[2]See Beckhard, Richard "Organizational Issues in the Team Delivery of Comprehensive Health Care," Milbank Memorial Fund Quarterly, July, 1972, Vol. L, No. 3, part 1.

[3]A particularly relevant program which is being used by primary care teams has been developed by my colleagues at M.I.T. under a grant from the Robert Wood Johnson Foundation. This is an instrumented (self-administered) series of task-oriented activities designed to help teams clarify goals, roles, etc. and to effectively manage inherent conflicts resulting from their interdisciplinary task. This program is also being considered for usage with new teams, clinic teams, and educational teams of health workers in educational settings. For information contact I. Rubin, M. Plovnick, or R. Fry at the M.I.T. Sloan School of Management, 50 Memorial Drive, Cambridge, Mass. 02139, (617) 253-4361.

[4]In the intern-residency program in Social Medicine at Montefiore Medical Center, Bronx, New York, a significant part of the new clinical curriculum is devoted to this type of content. For further information contact Dr. Harold Wise, Director of Internship & Residency Program in Social Medicine, Montefiore Medical Center, 3329 Rochambeau Ave. Bronx, New York 10467.

[5]These types of educational programs are being conducted as part of M.I.T.'s efforts to develop educational materials for health management under the Johnson Foundation grant. In the Boston University School of Nursing, for example, the effects of curriculum changes with these outcome goals are being monitored and evaluated in graduate nursing courses. Similar experiments are occurring in a physician assistants program at Northeastern University. For information contact R. Beckhard or E. Herzog, M.I.T. Sloan School of Management, 50 Memorial Drive, Cambridge, Mass. 02139 (617) 253-6673.

[6]See Rubin, I., and Beckhard, R., "Factors Influencing the Effectiveness of Health Care Teams," Milbank Memorial Fund Quarterly, Spring, 1972.

[7]From a series of actual interventions in four delivery settings, a specific outcome of educating delivery teams has been their desire to establish more effective channels of communication with the support organization in order to better relate to their patients' needs. In one neighborhood health center, for example, teams are proposing formal representation in regular administrative meetings and a specific amount of time each week to discuss issues concerning quality of care and specific problems in team and organization functioning. In this way, the deliverers can be sure of their organization's support before actively involving patients in systematic feedback programs.

[8]A further implication of this working relationship between team members is that teams should have influence in the decision as to who works on the team. In one setting, an outcome of team building was a negotiation between teams and the administration which resulted in hiring and firing procedures that the team could influence in several ways.

[9]These issues have risen again and again in interviews, team building and training. See Fry, R. and Lech, B., "An Organization Development Approach Towards Improving the Effectiveness of Neighborhood Health Care Teams, unpublished Masters Thesis, M.I.T. Sloan School of Management. Also see Gerstein, M., and Herzog, E., "Factors Influencing the Expansion of the Nurses Role in Primary Care Settings: A Study of the Graduates of a Nurse Practitioner Program," M.I.T. Sloan School of Management Working Paper #639-73, 1973.

[10]In an attempt to take advantage of these "learning bonuses" several hospital based clinics are planning with the Rubin, Plovnick, and Fry M.I.T. group to train their clinic teams as part of their intern-residency training programs. The clinic teams involved include house staff who are interested in learning more about improving health team effectiveness experienced by the clinic teams as a result of team training, the house staff (and the rest of the team as well) gain insight into the complexities of the patient family as an analogue to the problems they deal with on the health team. Further, house staff and other team members are exposed to, and learn a technology for managing these problems.

[11]For further references and background materials beyond those noted in these footnotes, the Institute for Health Team Development, 10500 Summit Ave., Kensington, Maryland, 20795, has compiled a thorough bibliography on teams. Of particular relevance is Wise, H., et al, Making Health Teams Work, Bellenger, 1974.

[14]In order to manage the "support role" of the rest of the health system it may be necessary to implement both educational programs for these support personnel and reorganization of the various subsystems involved. We at M.I.T., for example, are conducting educational programs for managers, administrative staff, and medical directors of neighborhood centers designed to help them better interface with back-up institutions, better manage internal staffs, and to better utilize scarce resources with similar organizations. (For more information contact R. Fry, M.I.T. Sloan School of Management, 50 Memorial Drive, Cambridge, Mass. 02139).

For examples of structural reorganization, see R. Beckhard's "Organizational Issues in the Team Delivery of Comprehensive Health Care," Milbank Memorial Fund Quarterly, July, 1972.

Date Due