AN ANALYSIS OF THE "TEAM" CONCEPT IN THE HEALTH CARE LITERATURE

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ABSTRACT

This thesis provides an account of the discussions of the "team" concept in health care literature since the early 1920s. It is argued that by adopting a historical, social constructionist stance, this thesis makes an original contribution to the literature. The research consisted of an inductive analysis of the "team" literature aiming to typify the ways in which the "team" concept has been constructed and historical, national or professional differences which have occurred. A history of "teams" which authors have reported is given. Rationales for using a "team" approach have included a shortage of professional personnel, the detrimental effects of specialization and the need for comprehensive care, and professional growth. Historically, claims about "teamwork" in health care have occurred in four phases: (1)a statement of basic issues and themes; (2)the emergence of ideas of flexibility and adaptability; (3)a period of optimism; and (4)the co-existence of positive, sceptical, and critical claims. The professional and national differences in claims making activities are also discussed. The least challenged claims about, and recent re-evaluations of, the "team" concept are also discussed.

SOMMAIRE

Cette thèse fourni un récit des discussions sur le concept de "l'équipe". Nous adaptons une perspective historique, <<social constructionist>> pour ainsi contribuer originalement à la littérature. Cette rechèrche consiste d'une analyse inductive de la littérature sur "l'équipe". Elle éssai de typifier les façons dont "l'équipe" a été construit historiquement, les différences professionnel qui y sont compris. Une historique des "équipes" inclus un manque de personnel professionnel, d'effets néfastes de la spécialisation et soins compréhensif, et l'élargissement professionnel. Historiquement, les réclamations sur le travail "d'équipe" dans les soins médicaux on existé parmi quatre phases: (1)les thèmes et questions fondamentaux; (2)l'émèrgence d'idées sur la flexibilitée et l'adaptabilitée; (3)une période d'optimisme; et (4)la coexistence des réclamations positive, sceptique, et critique. Les divergences professionnel et nationaux des activités de réclamations sont aussi discutés. Les réclamations les moins critiquées sur, et les ré-évaluations de, le concept "d'équipe" sont aussi discutées.

TABLE OF CONTENTS

I. INTRODUCTION

The status of the "team" concept in health care has, in recent years, been a subject of dispute. Some have claimed that a "team" approach offers a better way to provide health services than other forms of organization (McKinlay 1989), while others have expressed doubt about the validity of the "team" concept (Schmitt, Farrell and Heinemann 1988), or even the existence of health care "teams" (McClure 1984). There is a very extensive literature on the "team" concept. However, in spite of the extent of this literature, an analysis of the writings as a body of claims about the use, organization, philosophy, value or the validity of a "team" approach to health care is lacking. Particularly lacking is an analysis of the team concept grounded in the perspective of social constructionism, which will be used in the present thesis.

There has also been little attention in the literature to the historical development of the team concept. Although one in-depth historical review of the concept has been published (Brown 1982), it is somewhat dated, it did not cover several important discussions which emerged during the period which it reviewed and, again, it did not use a claims approach to the subject. I argue that, by providing an analysis of the claims which have been advanced about the team concept since its

inception, this thesis represents an original contribution to our understanding of the team concept as it has been applied to health care.

The literature on the team concept in health care is worthy of study on two counts. First, it spans a considerable amount of time, beginning at least as early as 1922 and continuing to the present day. Second, it is extensive: using the literature search strategy described here, it was possible to locate well over two thousand articles discussing the concept. Numerous books and scholarly dissertations have also appeared which address the topic, usually with the intention of providing a how-to approach to building teams or improving teamwork (e.g., Ducanis and Golin 1979). There have also been to my knowledge two annotated bibliographies on the team concept (Czirr and Rappaport 1984; Tichy 1974). As with the "how-to" books on teams, these bibliographies are mainly concerned with methods for establishing or training for teamwork in health care or other helping services.[1] In addition, there have been fairly extensive reviews by Crawshaw and Key (1961) on psychiatric teams, Nagi (1975) on general health care teams, Halstead (1976) on teams in chronic illness

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[1]Czirr and Rappaport's "Toolkit for Teams" is more explicitly practical in its intent. They maintain that "people beginning to work with interdisciplinary team training have a tendency to 'reinvent the wheel'" and their bibliography is intended to provide sources for strategies of "team" building, conflict resolution, meetings, records and time use (1984:47). In contrast, Tichy's practical purpose is more implicit, as there are frequent comments in her annotations that reviewed articles lack practical suggestions.

care, and Schmitt, Farrell and Heinemann (1988) on geriatric teams. Taken together, these writings suggest that the team concept has held a considerable and continuous fascination for authors in health care.

The overall goal of this thesis differs from most of the team concept writings by providing an account of the emergence and development of the discussions of the concept in health care writings. In the latter part of the introductory chapter, I review the past histories of the team concept and suggest why additional research on the topic is justified. The major reasons for additional research are (1)a general lack of detailed historical treatments of the team concept and (2)a specific shortage of research approached from the perspective of social constructionism.

In the second chapter, I more fully describe my method, the nature of the interpretive perspective adopted here, and the implications of this perspective for the interpretation of my findings. The method is characterized as a systematic and inductive literature review, indicating that the research and theoretical categories were not precisely and permanently specified in advance of the data collection (though some guiding questions were used from the outset and others emerged from the research process). The study proceeded first by drawing a sample of health care writings dealing with the team concept. Following this, information was collected on the authors themselves, their claims about the concept, and the

conditions which they have seen as relevant to the concept. The overall aims of the research, were (1)to provide the most general claims about team concept with a minimum of deviation from the views of the original authors (without violating the assumptions of the social constructionist perspective, as described below); (2)to characterize the origin of the claims according to appropriate categories derived from the documents themselves; and (3)to determine whether there have been any patterns or trends in the way these claims have been made (e.g., in support of, or opposed to the use of a team approach), with reference to their origin.

The interpretive perspective of social constructionism is also discussed in the second chapter. The thrust of this approach in the present context is (1)that statements which have been made about the team concept in the literature are regarded as claims which construct that concept, (2)that these claims can be better understood by viewing them in the context of the "conditions" under which they were made (such as the professional affiliation of the claims-makers, or the historical period in which they were advanced), and (3)that, in order to achieve this understanding, the researcher must adopt an agnostic stance towards the truth value of the claims, focusing instead on their subjective nature.

In the third, fourth and fifth chapters, I re-present the claims which have been made about the team concept. In the third chapter, I give a historical account of the main types

of teams that health care authors have reported. In the fourth chapter, I offer a topical treatment of the main rationales which authors have used to explain or justify a team approach. In the fifth chapter, I provide a historical account of the claims which have been advanced with respect to teamwork. I present these claims in four fairly distinct historical stages: (1)from the early 1920s to the early 1950s, (2)from the mid-1950s to the mid-1960s, (3)from the late 1960s to the mid 1970s, and (4)from the late 1970s to the present.

In the sixth and concluding chapter, I present some general remarks on the team concept literature and summarize the findings of my research. I further note the historical, national and professional differences in the way the team concept has been constructed. Finally, I describe what has been perhaps the least challenged view of the concept, and summarize the recent re-evaluations of it.

A. Definitions Used in this Thesis

Since much of this thesis is concerned with matters of definition (one kind of claim which is made), I summarize here the important definitions I will use. The "team concept" is perhaps the most difficult to describe in this way since, as this paper will show, it has been variously employed. But some general remarks should be made at the outset. Authors have seen the team concept as including an organizational entity (a health care team), a way of working together

(teamwork) and a philosophy underlying the approach. That is, through most of its history, the team concept has usually been used as an action-based term, rather than merely an idea. For simplicity of expression, I will refer globally in this paper to the team concept, using the more specific expressions only where they are appropriate.

Also for simplicity of exposition, I refer collectively to the data studied here as "the 'team' concept literature" or, even more simply, as "the literature". The reader should bear in mind, however, that qualifications apply to this reference. For reasons spelled out in the third chapter of this thesis, the "health care literature" was limited to professional journal writings which focus on the provision of health care, rather than on research or teaching about health care. However, even with this restriction, the documents were quite varied, including ones which were written by (or for) doctors, nurses, social workers, dietitians, physical therapists and other major health care professions, or written for general readership which would include many such professions.

What constitutes the history of these writings was also a function of the search procedure employed. According to the results of this procedure, the earliest document located was published almost seventy years ago and a substantial amount of team concept writing has continued up to the time of this report.

B. Past Historical Analyses

Considering the generally vast literature on the subject of the team concept, it is odd that there have been very few historical treatments (e.g., Brown 1982; Ducanis and Golin 1979:3-5; Tichy 1974:vi; Wise 1972), though many authors have referred vaguely to its history. Moreover, with one exception, those histories that do exist are usually superficial, often citing Barker's (1922) seminal article, mentioning the importance of the second world war and noting the significance of the 1960s community health care movement in the U.S. for establishing the team approach. Particular attention is sometimes also given to team development at Montefiore Hospital and Dr. Martin Luther Jr. King Health Centre (both in New York) as important for the team concept, but few details are provided. All in all, one is immediately struck by how little has been written historically on this topic, a clear indication that additional work of this nature is merited.

There are two exceptions to this generalization. First, Wise's (1972:438-439) account of historical precedents to his interdisciplinary health care teams at the Martin Luther King Health Centre is remarkably detailed, especially considering that its main purpose is not a historical treatment of the topic. Wise refers to earlier health care teams including: a "family club" in South London during the late 1920s (popularly called the Peckham Experiment) which used a team approach; a

home care team developed at Montefiore Hospital in 1948; a comprehensive care team also affiliated with the same hospital but operating out of a health centre from 1950 to 1958; and the use of the team approach in both South Africa and Jerusalem by Sidney Kark (also in the 1950s). Wise reports that these precedents had a major influence on the project under his direction at the Martin Luther King centre.

Another historical work, a chapter by Brown (1982), deserves special attention both because of its considerable depth and because, in some ways, it parallels the perspective adopted here. In his chapter, Brown presents an analysis of the forms of team talk which have appeared in health care writings, asking specifically "why the language of teamwork has been so extensive in recent years" (1982:3).

To account for this, Brown notes several interconnected ideologies or rationales which have been used to promote teamwork in health care, as well as the professional interest groups (especially nurses and allied health workers) which have been involved. These rationales have included a reaction to modernization (especially specialization), an appeal for the rationalization of health care to improve efficiency, and an appeal to recognize the expertise of non-medical (and especially nursing) health care personnel linked with an egalitarian ideology. According to Brown, early authors writing about the team concept suggested that specialization in medicine led to a "missing social component" in health

care. As well, the arguments for a recognition of the expertise of non-physician health care professionals has been connected with the ideology of levelling: i.e., that these experts should play more of a role in decision-making over diagnosis and treatment.

In addition to these ideologies being interconnected, Brown argues that the dominance of any one of them has varied historically, and he identifies three stages or phases in this process. In the first, "inception", phase (roughly between the two world wars) the modernization rationale was the basis for much of the team talk. Writers at this time were mostly concerned with the flow of information between health care professionals. So, for example, Barker (1922) had suggested the need for the position of a coordinator in order to integrate the different kinds of information provided by an ever-increasing variety of specialists into an appropriate diagnosis or treatment plan for the general practitioner.

In the second, "high tide" phase (roughly between the second world war and 1970), Brown notes that there was a huge increase in talk about the team concept. Following the war, nurses returned to the domestic scene to find their positions filled by non-nurse and non-professional staff. One of the greatest concerns at this time was the definition of a unique "nursing function", a means to establish the expertise of professional nurses versus their replacements. With this concern in mind, and in the context of expanding hospital

care, the concept of team nursing developed, with head nurses overseeing the ward staff and professional nurses (or advanced nursing students) overseeing nurse's aides. At roughly the same time, the ideologies of modernization and specialization were taken to indicate that the general practitioner had become obsolete--or was quickly becoming so--and could be effectively replaced by an interdisciplinary team.

In the latter part of the high tide, Brown notes that there was a wave of optimistic writings on health care teams. To the earlier ideologies of modernization was added egalitarianism. As this concerned the internal relations of the team, it was argued that, because of their expertise, all team members should be regarded as equals and that decision-making should be democratic. This new ideology was also extended to the patient populations served by teams. Under the impetus of the U.S. Office of Economic Opportunity's funding of community or neighbourhood health care centres, new ideals of social activism, community health, preventive medicine and equal access to health care were voiced.

In the final, "re-evaluation" phase (from the 1970s to the to the time of Brown's writing) Brown argues that there emerged a general disillusionment with the whole team concept as it had developed up to that time. Many writers had begun to question team care, especially as it had been formulated in the latter part of the "high tide", and advocated systematic evaluations of team care (e.g., whether such care really works

or under what conditions it does or doesn't work). Brown suggests that ideologues of the high tide period have to reckon with the possibility that levelling or more diffuse authority on teams may not lead to greater effectiveness. In conclusion, Brown notes (1)that the team concept has often been rhetorically or ideologically employed; (2)that a team approach may not necessarily be a good thing; (3)that, in fact, health care professionals may be unequal; (4)that the professional ambitions which have driven much of the team talk in health care may be irrelevant or detrimental to patient welfare (Brown 1982:17). According to Brown, then, in the re-evaluation period, ideological rhetoric had confronted reality.

Although Brown's chapter provides an in-depth presentation of "team talk" for literature published before the beginning of the 1980s, the present account will improve upon Brown's work in several ways. First, despite the amount of information he provides, the space restrictions of his chapter do not allow as extensive a discussion as I am able to provide in a thesis. Even for the historical period covered by his chapter there are many other issues which are raised and require discussion (a point Brown fully acknowledges). Second, there are other issues concerning the team concept which have occurred since the time of his publication which are needed to bring the discussion up to date.

Third, by invoking the influence of ideology, Brown's analysis raises questions as to why the re-evaluators--with which Brown apparently is in agreement--became disillusioned. While arguing that he has disclosed the ideological motivations driving the earlier discussions, Brown gives no reasons for discounting ideological grounds for his own position, or the position of the re-evaluators. (It may be that this type of problem is inherent in any discussion of ideological motivations.) Another way of putting this point is to say that Brown's analysis is not a social constructionist argument[2]--a point I will more fully develop in the next chapter. Aside from the problem noted above, the distinction he makes between "ideology" and "reality" is not a legitimate social constructionist strategy (and hence will not be the approach of the present thesis). Thus, in these ways, one can justifiably view his argument as a socially located claim as well.

There are points of convergence between Brown's work and my own. For one thing, though my conclusions were arrived at independently, there are similarities between our characterizations of the claims advanced during the period covered by Brown's study. Moreover, his 'historical-linguistic' approach, focusing on 'team talk' with a

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[2]Of course, Brown does not claim to be following this perspective. The import of my remark here is that, by departing from the logic of the general constructionist approach, he raises some questions about his own argument.

historian's eye, is similar to the approach I use here. I am concentrating on claims in the team concept literature, and much of this is most appropriately portrayed in a historical light. Even so, there are important differences between our perspectives--particularly in terms of the reality/ideology distinction--which can be fully appreciated only after a deeper understanding of the nature and the logic of the perspective used in the present account.

II. METHOD

As with any research, evaluating the validity of social constructionist research and the generalizability of its results rests on the way in which claims are located, how these are examined and how the researcher interprets the data. Neither the possibility of replication or disconfirmation of the researcher's interpretations need be excluded from the social constructionist research process. It is fair, then, for the critical reader to ask for as many details as possible about this process.

The method employed in the present research involved an inductive (but systematic) content analysis of documents appearing in the health care periodical literature. These documents, and statements within them, represent the data I have analyzed. In this chapter, I describe the criteria used to define the population and sample of documents reviewed, the kinds of information which were collected, and the approach used in interpreting this information. Throughout the research, the main goal was to provide an account of the "team" concept claims and if (or how) the discussions have varied over time or across other conditions (e.g., nations or professional groups), in order to better understand how the team concept has been constructed in health care writings.

A. Locating the Documents

Locating the relevant documents for investigation was a two-step process: a search procedure, aimed at reconstructing, as fully as possible, the population of team concept writings, and a sampling from this population of those documents which would be theoretically useful and relevant (in the sense described below).

The search began by using the Medline CD ROM service, available for the years 1966 to the present. Medline was searched for documents using "TEAM*" in their title. ("TEAM*" is a Medline search term which, when used in this way, locates all documents in using words beginning with "team" in their title. This term is used elsewhere in this essay to refer to these kinds of documents.)[3] This procedure yielded over 2000 documents. After sampling documents from this population (by the procedure described below) the bibliographies of the sampled documents were scanned in order to locate "TEAM*" articles published before 1966. The process was repeated as documents were added to the sample (either by the backward searching through document citations or from additional Medline-located articles) until no additional earlier documents were located. The goal of this search procedure was to reconstruct, as completely as possible (given the sampling

[3]It was judged that searching by title would be more likely to locate articles that dealt primarily with the "team" concept than, say, using the same term to search the abstract or keyword field in Medline, which could include articles dealing mainly with other topics.

and search restrictions), the population of documents which would have been located if the Medline service had been available for earlier time periods. This procedure yielded over 60 documents published before 1966.

In sampling from this population, I attempted to locate data which would be both theoretically useful and relevant. In the context of inductive qualitative research, "theoretically useful" cases are those which help to generate as many categories or qualities of categories as possible (Glaser & Strauss 1967:48). According to Glaser and Strauss, the optimal way to ensure the theoretical purpose and relevance of resulting data is to sample theoretically:

> Theoretical Sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is controlled by the emerging theory, whether substantive or formal (1967:45, emphasis original).

"Relevance" in this case generally refers to documents which are seen as relevant by the team concept authors.

While in many cases I did adhere to theoretical sampling, some additional sampling decisions were made. Thus, in answering the question of "Where to look next?", it is possible to distinguish conceptually between my decisions and claims-makers' decisions.[4] Two of my key decisions were (1)to

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[4]Actually, as regards sampling, the difference between the "my decision" and one which is "theoretically useful" (i.e., following from the views of the claims-makers themselves) lies on a continuum. In other words, even those

reduce the enormous numbers of documents to a manageable size for a single researcher and (2)to sample documents from different sub-populations, in order to increase the representativeness of the data and the generalizability of the results and interpretations.

Some of the subpopulations which were varied in the sampling of documents were:

> Professional Groups. Following an examination of the first few documents, it was apparent that there were differences in the character of team concept discussions according to professional identity. To explore this dimension of the discussions, I continued to sample documents to represent the views of the various professional groups.
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> Source Type. In the main part of my research, I limited myself primarily to documents published in journals or periodicals, rather than books, institutional or government documents, unpublished masters or doctoral work, etc. This was my decision, made in the interests of manageability.
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> Document Types. Some of the types of team concept documents which were not used included those where the concept was discussed solely in the context of research, teaching, dentistry, or surgery. Also, as I wished to examine the team concept in general, I preferred articles which discussed in general terms, rather than as applied to a very specific health condition (e.g., stroke).
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> Source Nation. In the interests of reducing the number of documents, I elected to include only articles by authors who identified themselves as working in the United States, Canada, or Britain.

Some concern might be raised regarding this exclusion of documents, particularly when they were not based primarily on

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sampling decisions which I initially made for reasons of expediency or manageability were considered by some claims-makers as being important for the team concept.

theoretical sampling but on decisions of the researcher. However, I judged that, by making exclusions which were systematic, the documents which remained would be comparable in a number of ways and, given the systematic nature of the exclusions, any future attempt to test the generality of the findings and interpretations by examining the excluded literature would be made easier.

The documents which remained following these exclusions were general writings from periodicals addressing the team concept in the delivery of health care. These included letters to the editor, position papers, reports of experiences with team care and studies. The documents included those written by doctors, nurses, allied health professionals (social workers, rehabilitation counsellors, health educators, dietitians and physical or occupational therapists, etc.), university professors and other researchers, representatives of professional associations, government workers and students. At the time of publication, authors of all the materials came from three countries: most commonly from the United States and less commonly from Canada and Britain.

B. Collecting the Claims Data

Although the present project was to a certain extent inductive, I did begin with two general guiding questions, namely: (1)What does the author mean by a health care "team"? and (2)What is meant by "teamwork"? (These were topics which were discussed in the first documents I reviewed and were

addressed in all other documents reviewed afterwards.) Additional guiding questions emerged as the research progressed. For instance, many authors discussed the philosophy underlying the team approach, and it seemed relevant to note this for all documents which dealt with this topic. Also, many authors discussed the rationale or impetus for team care; thus it became relevant to note what authors saw as the condition(s, necessitating a team approach or concept. Finally almost all the writings addressed the results of team care or the conditions necessary for, or the barriers to, the implementation or success of a team approach, and I regularly noted what authors claimed in this respect.

In addition to answers to these guiding questions other data were collected on the authors themselves: their institutional and professional affiliations (and title or position) and the country in which they were working at the time of publication. In contrast to the above, the questions which guided this part of the data collection did not emerge from the earlier research (though authors often claimed that such differences are relevant to the team concept). Instead, the information was sought out to provide a more complete context for the discussions, and to explore whether team concept claims differed according to nation, author's position or professional group.

C. Interpreting the Claims:

The Social Constructionist Perspective[5]

The social constructionist perspective has informed my whole approach to the topic of the team concept, the types of questions I have asked when looking through the documents, and the interpretations and implications which could be drawn from my findings. In this section I will provide an outline of the general constructionist position, indicate how this perspective informed my interpretation of the claims, and discuss some of the difficulties associated with such research.

Perhaps the most familiar version of social constructionism is found in the writings of Spector and Kitsuse (1977), who have applied the perspective to the study of "social problems". However, as Schneider (1985) and others have noted, several of the central tenets of social

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[5]In deriving a general constructionist approach, I have been influenced considerably by the work of Spector and Kitsuse (1977), Pfohl (1977) and the review by Schneider (1985) concerning social constructionism in social problems research; the critique of this tradition by Woolgar and Pawluch (1985) and the responses to this by Spector and Kitsuse (1986) and Gusfield (1986); the critical essays on labelling theory (or the labelling perspective) by Rains (1975) and Petrunik (1980); Berger and Luckmann's (1966) statement on the construction of reality in everyday life (1966); Garfinkel's Studies in Ethnomethodology (1967) and the re-readings of works in this tradition by Mehan and Wood (1975) and Heritage (1984). It should be clear from my statement of this perspective that I have not remained entirely faithful to these many different schools of constructionism; nor, do I think, should I have been. Though I have tried to acknowledge credit where it is due, my purpose throughout this section is to derive from these ideas the most logically consistent and appropriate perspective for my topic.

constructionism were earlier stated in phenomenological and ethnomethodological writings (e.g., Berger and Luckmann 1966; Garfinkel 1967), labelling and value conflict approaches in social problems (cf. Spector and Kitsuse 1977:60-63) and similar approaches in the sociology of science (Latour and Woolgar 1979).

Despite the differences between these social constructionist approaches they share three basic premises:

> (1)that members of society (actors, claims-makers, labellers, etc.) create or construct reality, or some aspect of it, which cannot be understood in isolation from these processes;
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> (2)that one of the primary methods of constructing social reality is symbolic interaction or the use of language (by making claims, giving accounts, designating deviants, etc.); and
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> (3)that the social constructionist researcher approaches these constructions with a stance of methodological agnosticism. That is, the researcher suspends judgements as to whether or not these constructions refer to an entity independent of the constructive process (i.e., "objective reality") and, consequently, whether or not they have certain qualities (e.g., good or bad). In order to explore the subjective side of social reality, social constructionists limit themselves to a presentation of the views of the participants themselves, or to an interpretive representation which is consistent with their views.

To these premises, some social constructionists add that a given individual's participation in the constructive process may differ from that of others, contingent with one's "location" in social reality (e.g., one's gender, class or occupation).

Two additional variations among schools of social constructionism are important in the present context. The

first concerns the types of phenomena attended to by the researcher. Social problems researchers (e.g., of the Spector and Kitsuse tradition) have usually focused on conflicting claims about reality. Phenomenological writers such as Berger and Luckmann (1966) and ethnomethodologists like Garfinkel (1967) have been more willing to address commonsense phenomena which have a higher degree of consensus among members of society.[6] A second related difference concerns the degree to which the perspective is applied. Radical claims of the ethnomethodologist, for example, hold that all reality is socially constructed. The present account undertakes a partial return to the perspective of these earlier works, by viewing all reality as socially constructed and by viewing the constructive processes as both potentially variable and potentially consensual.

Although I have largely followed Spector and Kitsuse's (1977) "natural history" style of studying claims-making activities in the construction of "social problems", there is one important difference between our approaches. Specifically, I have extended their perspective to include a study of claims-making in the construction of an "organizational entity". To be sure, team concept authors

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[6]Though in the case of Garfinkel's (in)famous breaching experiments, the researcher deliberately violates "what everybody knows" in order to reveal the constructive processes which go into making up this taken-for-granted reality (Garfinkel 1967; Heritage 1984:78-83; Mehan and Wood 1975:107-108). Thus, conflict is introduced in what are otherwise "routine" situations.

have often referred to "problems" of health care in advancing their claims, but they have focused on the team concept, which they see as an organizational response justified by these problems. Thus, the focus of this thesis is on their claims about this organizational response.[7]

In the present context, then, the social constructionist approach translates into arguing that the authors who discuss the team concept are making claims about, and thereby creating that concept. It is constructed, in that authors regularly offer claims or accounts about (1)the nature of health care teams and teamwork, (2)reasons for the existence of a "team" approach, and (3)evaluations of such an approach. In short, they suggest a way in which the team concept should be regarded or experienced by others. Further, the concept is socially constructed in that the claims appear in a public forum--journals, which are accessible to others. Consistent with the constructionist researcher's agnostic stance, I make no assumptions regarding the objective status, desirability, usefulness or necessity of the team concept. Instead, I have

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[7]Because of their aim to create a distinctive sociology of "social problems", Spector and Kitsuse focus on conditions which claimants view as problematic, rather than on the construction of organizational entities seen as remedies to these imputed problems. In their discussion of the (revised) natural history model, Spector and Kitsuse seem to allow for an extension of their perspective to "organizational entities" (Spector and Kitsuse 1977:151-154), which includes collective responses to, or evaluations of, institutional responses to "social problems", but this is not their primary concern. For some indication of how other authors have treated organizations as a social constructions, see Fine's (1984) review of "negotiated orders" research.

searched for types of claims or constructions and inquired whether or how these have changed over time, or with other conditions (e.g., history, professional group, nationality, etc.).

As with the data collection process, interpretation was undertaken with the aim of providing the best account of the character of the claims and the ways they have varied. In addition to summarizing the claims, then, I noted authors and institutions which were regular sources of publications or frequently cited in the works of other team concept writers, to see if major contributors or centres of team concept discussions could be identified. In general form, the data on authors' position, professional identity, nationality and date of publication were regarded as "conditions" under which claims were made, and I explored the possibility that the nature of the claims was different under different conditions (e.g., that they varied historically, across professional groups or countries, etc.).

To avoid misunderstanding, several additional points about my interpretive perspective merit mentioning before reviewing the claims themselves. First, some critics hold that the social constructionist researcher denies objective referent of claims about the world and reduces all accounts or claims to a matter of perspective.[8] However, the social

[8]One form of this objection is to argue that, as a radical perspectivism or scepticism, social constructionism is said to be self-defeating, since why should we follow the

constructionist researcher need not deny the objective validity of the claims studied. Instead, the researcher should adopt a stance of methodological agnosticism, suspending judgement on the referents of claims in favour of insights about the subjective side of social reality. The constructionist's stance to the referents of claims, then, is one of agnosticism, not atheism.[9] This distanced perspective is valuable for attempting to be as impartial as possible about the discussions and, properly fulfilled, it yields insights which other methodological stances often do not provide (cf. Gusfield 1986).

A related critique holds that social constructionists admit some objective reality but that objectivity and subjectivity are (dubiously) assigned so as to suggest that the sociologist has a privileged point of view--what Woolgar and Pawluch (1985) call "ontological gerrymandering". According to Woolgar and Pawluch, constructionist researchers themselves claim or imply that the objective referent of claims has a certain character (e.g., in the present analysis,

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social constructionist's perspective instead of others'? Other critics simply argue that there are objective bases for many of the claims or accounts that constructionists study. See, e.g., Coleman's comments on the treatment of sex identity in Garfinkel's Studies in Ethnomethodology (Swanson, Wallace and Coleman 1968).

[9]The terms agnosticism and atheism seem apt, since this debate is basically a metaphysical one. Moreover, it is curious that to my knowledge there is no comparable debate in the sociology of religion which, among other things, studies individuals' orientations to a "God" or other "religious object" without debating his/her/its objective existence.

that teamwork has a certain, constant character) while the claims themselves have another character (e.g., that claims about "teamwork" have varied over history). Woolgar and Pawluch also note that constructionist arguments usually invoke objective conditions ("social forces", "cultural conceptions", "social structure", etc.) to explain the variance between the claims and objective reality.

It should be noted that the social constructionist does, in fact, assert or imply that something is objective, namely the claims themselves (cf. Gusfield 1986). If these were not regarded as empirical, it is difficult to imagine how sociological research could proceed. Again, what the researcher regards from a distance, is the truth value of the claims themselves. Further, I would argue that the researcher should regard both the referents of claims and the "conditions" as social constructions, subject to the same methodological agnosticism.[10] Moreover, rather than attempting to explain social reality, a constructionist project should seek an interpretive account of how claims have (or have not) varied or changed under different conditions.[11]

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[10]In the ethnomethodological expression, the claims about the aspect of social reality at the focus of the research and the "conditions" are "mutually constitutive", each dependent on the other for their meaning (see Mehan and Wood 1975:71 for perhaps the clearest presentation of this idea).

[11]Gusfield (1986), writing on social problems research, and Petrunik (1980), writing on so-called labelling theory, prefer to characterize social constructionism as an approach or a perspective rather than a theory. To characterize social constructionism as a "theory" too often invokes the discourse

There are, however, two practical difficulties associated with the constructionist approach. First, as Woolgar and Pawluch (1985) correctly note, social constructionists lack a well-developed metalanguage, i.e., a way of writing about claims or accounts which does not imply a reference to their objective validity. One constructionist strategy has been to place the "problematic" entity within quotation marks (i.e., the team concept), or by using qualifying phrases (e.g., "an imputed quality of 'teamwork' has been ..."). However, according to Woolgar and Pawluch, these strategies imply that other expressions used by the researcher (e.g., professional identity) are to be viewed as objective. This strategy becomes even more complex given my argument that "conditions" and "problems in health care" also be considered as socially constructed, which threatens to litter the page with quotation marks or qualifying terms. Perhaps the best that can be done is to be explicit about one's agnosticism from the outset and proceed.

For stylistic reasons, I have largely avoided the use these conventions within the body of this thesis. However, even where the team concept is set off in this way while other terms are not, I am not suggesting that it is any less constructed than other expressions used by claimants or in

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of positivist-realist social science, necessitating a discussion of "objective facts" and "explanations". It is mainly because of this discourse shift that many of the confusions arise (ontological gerrymandering, the apparent failure to confirm labelling theory hypotheses, etc.).

this essay. What is implied is that (1)numerous authors writing in the health care literature have made this social construction the focus of their accounts and (2)that they account for it in terms of other constructions which are not their primary concern. Thus the team concept is, in the claimants' views, the problematic construction, in need of discussion or debate (cf. Gusfield 1986).

The second practical problem concerns the actual attitude of the researcher. As Spector and Kitsuse (1986) have remarked, to adopt an agnostic attitude to one's subject is a counter-intuitive feat of sociological imagination which is difficult to maintain.[12] Still, I have endeavoured throughout this thesis to maintain a distanced approach, for the logical consistency and value of constructionist research depends upon such a stance.

Having now discussed the method of my research and the perspective by which my findings were interpreted, I turn now to more substantive matters--namely, an account of the claims which have been made about the team concept in health care.

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[12]In particular, it is very difficult to maintain an agnostic stance when dealing with claims which are phrased in a research discourse. As trained sociologists, we are often inclined to assess research claims for their truth value, rather than to seek to understand them in a social constructionist fashion, as claims among others. Thus, my use of expressions such as "report" or "study" in describing research claims refers to the style in which these claims are made, and need not be taken to mean that they be regarded differently from non-research claims. For present purposes, they may be considered as different genres of making claims.

III. HEALTH CARE "TEAMS"

To set the stage for later discussions, it may be useful to describe in some detail ways in which the "health care team" element of the "team" concept has been used. In this chapter, I give a synopsis of the various types of team which have been discussed, the professionals which have been included on them, their basic goals and the patient populations they have served. In the historical overview section, I present what appear to be the five main early types of team and compare these to later versions. In the last part of this chapter I turn to a brief discussion of the differences between teams as they have been constructed in the U.S., Britain and (to a lesser extent) Canada.

A. Historical Overview

Perhaps the earliest report of a team approach came with Barker's 1922 address to the Yorkville Medical Society of New York city. Barker's vision of the health care team involved a general practitioner working in cooperation with specialists and other consultants--including laboratory workers, roentgenologists, surgical specialists, and consulting diagnosticians. According to Barker, this team was able to provide integrated diagnostic plans for individual patients, though the general practitioner was to be the primary

caregiver. Later developments of this concept by Silver and Stiber (Silver 1958; Silver and Stiber 1957), a physician and a social worker with Montefiore Hospital's experimental Family Health Maintenance Demonstration Project, and by Drew (1953), a physician at the University of Minnesota Medical School, expanded this team concept by including social workers or psychiatrists (non-team consultants in Barker's scheme). Further, both the Montefiore project and Drew's scheme considered the whole team as the caregiver. This theme is most pronounced in Silver's work (1958), which announced the end of the era of the general practitioner, whose former role in health care, Silver argued, could be more effectively fulfilled by the health care team.

In these later developments of Barker's vision, the teams were concerned with health care as given in a clinic setting. A slightly different early picture of the team was given by Rogers' (1932) presentation to the National Nursing Organizations convention, concerning patient care in a hospital setting. While her paper does not define the team as clearly as the above writers, her discussion of teamwork refers to administrative staff and front-line professionals from a variety of departments. These departments included nursing, medicine, dietetics, research, and x-ray and other laboratory workers. Some later illustrations of Rogers' view of the team can be found in Field (1955), Cayne and Stolnacke (1967) and McDougall and Taylor (1978). Most of these later

discussions do not deviate greatly from Rogers' vision, as all these authors see the team as being the interrelated departments of the hospital and have confined themselves to patient care given in the hospital setting.

The writings report a third early development of the team concept. Following the second world war, discussions of psychiatric teams began to appear. These typically consisted of a psychiatrist team leader, a psychiatric social worker and a psychologist, though authors regularly noted that other professionals could be called on to assist the core team members.

One version of the psychiatric team is found in the context of orthopsychiatry or child guidance. In his presidential address to the American Orthopsychiatric Association in 1947, Spafford Ackerly claimed that the team approach was fundamental to orthopsychiatry, saying that "when the psychiatrist, social worker and psychologist were brought together as full fledged members of a team in the early 20s, orthopsychiatry was born" (1947:191).[13] Later writings on orthopsychiatric teams emphasized their preventive philosophy in providing health care (e.g., Fox 1949; Gluckman 1953; Keliher 1949). Although it was generally agreed that these teams would be responsible for intake and assessment, authors differed as to whether a team approach to actual care was

[13]A similar idea is expressed in Matthew's (1960) retrospective remarks on the formation of the American Orthopsychiatric Association.

necessary. The issue of what stage(s) of care the team approach was best suited for was a main subject in many of the later papers on the orthopsychiatric team.[14]

A second thread in the early discussions of psychiatric teams concerns those which provided general psychiatric care (e.g., Bernard and Ishiyama 1960; Connery 1951; Crawshaw and Key 1961; Hutt, Menninger and O'Keefe 1947; Weinberger and Gay 1949). These were also clinic teams but, serving adult patients, they were more often presented as reactive rather than preventive, dealing with patient problems as they were presented to professionals at clinics.[15] Still, they were loosely connected to the child guidance movement, either by professional affiliation (e.g., Hutt's lectureship in child guidance) or, by their own account of the psychiatric team tradition. Further, they were initially connected with the war, either as a catalyst for the development of the team in times of crisis and staff shortages, or by the authors' work in veterans' administration clinics (e.g., Weinberger and Gay

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[14]See also the series of papers in the 1960 volume of the American Journal of Orthopsychiatry, from which Matthews' address is taken.

[15]Although Hutt, Menninger and O'Keefe's article deals mainly with clinic teams, they additionally noted that neuropsychiatric teams were used "in a wide variety of overseas and zone-of-the-interior army installations, such as general, regional, and station hospitals; neurological and neuropsychiatric centres; convalescent hospitals; consultation units (mental hygiene units); disciplinary barracks and rehabilitation centres for prisoners; induction stations; personnel centres and redistribution centres; and separation centres" (1949:103).

1949; cf. Crawshaw and Key 1961). Later developments along the lines of these early psychiatric teams were reported by Tietz (1951) and Lesser (1955), and especially by Modlin and his associates working at the Menninger Clinic in Kansas (Modlin and Faris 1954, 1956; Modlin, Gardner and Faris 1958). As with the orthopsychiatric teams there was considerable disagreement concerning whether, or in what proportions, the team approach should be applied to intake, diagnosis, or caregiving (cf. Crawshaw and Key 1961).

Still a fourth strand in early writings concerned the nursing teams created in the late 1940s and early 1950s. These teams, which were usually assigned a specific group of hospital patients or a particular ward, generally included a team leader (a graduate or advanced student nurse), nursing aides and, in some cases, maids or other maintenance staff. The head nurse, while not usually considered a member, was nonetheless responsible for the team (Berger and Johnson 1949; Brackett 1953; Calabrese et al. 1953; Carberry 1952; Jones and Ellsworth 1949; Kuntz and Rogers 1950; Nursing Staff 1955; Struve and Lindblad 1949). Taken together, these early writings on nursing teams offer a fairly homogenous presentation of the team approach to patient care, with little difference in terms of team composition or structure. The greatest concerns for these authors were how to schedule the team members, the specific duties of each, and how advanced the education of the student nurse should be before leadership

was possible. The only further development of these nursing teams concerned the patient population, as some later papers reported the use of nursing teams in psychiatric facilities and the community (Peplau 1953; Christman and Boyles 1956).

A final type of team appears in these early discussions. Several articles from the 1950s dealt with rehabilitation teams, which were typically concerned with patients with multiple disabilities (Caldwell 1959; Patterson 1959; Whitehouse 1951, 1953). The roster of professionals on these teams varied, but generally included a medical practitioner (seen as essential by Caldwell), vocational or other counsellors, and educational personnel. The goals of these teams were largely confined to diagnosis and evaluation, especially as these occurred in evaluation conferences.

All of the early discussions of teams (up to the mid-1960s), then, fall fairly easily into five basic types: general practice clinic teams, general hospital teams, psychiatric clinic teams, rehabilitation teams and nursing teams. Most of later authors either continued along these same lines of thought or modified or synthesized the earlier conceptions into new forms.

Writings on both the hospital and general practice clinic teams underwent significant revisions during the late 1960s. One change concerns the U.S. hospital teams. Whereas Rogers' (1932) early scheme concentrated on those professionals who were directly concerned with patient care, some of the later

writings began to address teams of administrative staff. In the first articles of this kind (Dykema 1965; Igmire and Blansfield 1967) it was not clear to what extent the team was involved in patient care, but in the most recent articles the discussion is wholly centred around administrative staff and a new concept of the executive team had fully emerged.[16]

In the U.S., one new kind of team was the hospital home team (Reese 1968; Scher and Topkins 1966) and its British clinical counterpart, the domiciliary health team (Crombie 1970; Unsigned 1965).[17] In either case, primary care was given in the medical setting, but the team was also involved in follow-up care or assessment in the patient's home. At least according to Scher and Topkins (1966), this necessitated the inclusion of the patient's family as a team member as well.

Also beginning in the mid-1960s, a virtual flood of articles appeared announcing the formation of interdisciplinary "community health teams", in clinics in North America (Aradine and Hansen 1970; Beloff 1968; Hohle, McInnis and Gates 1969; Jansen 1968; New 1968; Topf and

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[16]For more on the distinction between executive and patient care teams, see the articles Brown (1989), Christman and Counte (1989). In fact, the entire Winter 1989 and Spring 1990 issues of Nursing Administration Quarterly were devoted to the topic of the executive team.

[17]Wise (1972) reported the creation of home teams at Montefiore Hospital in New York as early as 1948. However, no specific references were given and I was not able to locate any documents reporting these earlier home teams in my search.

Byers), Britain (Anderson 1969; Burn 1970; Fry, Dillane and Connolly; Hasler 1968; Hasler et al. 1968; Thornton 1966; Trounson 1969) and Canada (Menzies 1965).[18] In many cases these community health teams were connected with the Office of Economic Development in the U.S., the National Health Service in Britain and local government agencies in Canada.

In addition to a more diverse roster of personnel on these teams, there was a renewed emphasis on the goals of illness prevention and health maintenance. In order to pursue these goals, authors argued, it was necessary to see a much wider variety of problems as falling within the domain of health care--from mental and physical health, to poverty and unemployment, to malnutrition in the home, and even to educational placement. Further, this preventive aim was seen as necessitating the inclusion of the new role of the health educator, filled most often by a public health nurse (in North America) or a health visitor (in Britain). There was also a perceived need for regularly consulting with psychiatric professionals and social scientists. In a sense, then, these writers fused themes which had been present in the earlier team concepts of the general practice and orthopsychiatric

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[18]Although their histories mention earlier instances of the "team" concept, Tichy (1974) and Wise (1972) see the emergence of interdisciplinary health care teams as the real beginning of the "team" approach. Wise's history notes earlier instances of such "teams" in Britain, South Africa and Israel and the U.S. but most of his examples were either not cited sufficiently for me to follow up or the documents reporting them were outside the "TEAM*" search criterion.

clinics. At least at the time of their inception, they were presented as "community health teams" in the double sense of being in the community (as opposed to the distant hospital) and of serving the communities rather than only the patients who came in for diagnosis or treatment.

From the late 1960s one also witnesses a greater specification of the types of problems or populations to which the team concept has been applied. For example, in the last two decades, it has been frequently applied to diabetics (Cayne and Stolnacke 1967), stroke (Christensen and Lingle 1972; Wood-Dauphinee et al. 1984), and geriatric populations (e.g., Beattie and Crawshaw 1982; Bottom 1980; Gaitz 1970; McVey et al. 1989; Saltz et al. 1988).

In addition to all these relatively clear definitions, there are two types of claims which more vaguely refer to a team. First, also in the late 1960s, nurses began to submit articles which mention nurse-physician teamwork within the hospital (Bates 1965; Bates and Kern 1967; Peeples and Francis 1968). Though not explicit in their definition, their discussions are limited to the interaction between nurses and doctors, suggesting that these two professions might be the team in question.[19] Second, throughout the history of the concept, it has been periodically suggested that the entire

[19]Considering her emphasis on nurse-physician interaction, Rogers' (1932) work might also be considered an early discussion of this type of team, as well as being directed to the hospital team.

system of health care be regarded as the team. For example, Magraw, an employee of the Bureau of Health Services in Maryland, conceived of a multi-levelled team approach, which included (1)"medical microorganization" (personal physician plus assistants), (2)"medical macroorganization" (physician groups), (3)hospital organization, and (4)a "super organization, by which we mean organization of medical facilities and health agencies and institutions at a community and regional level in relation to community, regional and even national programs and planning" (1968:803). The definitions are less clear, however, in proposals for educating "the health team" (Baumgart 1968; Christman 1970; Girard 1967), in Schreckenberger's "playing for the health team" (1970), in Appleyard's (1979) critique of the proposals for multidisciplinary area review boards, or in the papers by Keliher (1949) Schulte (1965) and Carter (1966).

Finally, beginning in the late 1970s there arose a new view of the team as a "fiction" or a "myth" (esp. Erde 1981; Given and Simmons 1977; Henderson 1981a; McClure 1984; Temkin-Greener 1983). Previous writers had showed some evidence of scepticism or ambivalence toward the team concept. For example, earlier authors had often, if unsystematically, used quotation marks around the words team concept, teamwork, health care team. There had also been occasional doubts expressed about how distinct the team was from health care generally, suggesting that teamwork was what health care

professionals had been doing all along (Bowen, Marler and Androes 1965; Rae-Grant and Marcuse 1967).

However, it is fair to say that up to the mid-1970s (and to some extent since then) most contributors to the discussion had adopted a matter-of-fact stance towards health care teams, even if their reference point was not always amenable to classification. This matter-of-fact attitude is particularly evident in the periodic claims to new membership on health care teams, whose authors saw themselves as joining something (Cain and Kahn 1971; Dykema 1965; Gluckman 1953; Hohle, McInnis and Gates 1969; Holmes 1972; Lietz 1966; Frize 1989). There is, then, good reason for seeing the team-as-fiction writers as providing a new way of talking about the team.

From this overview, we can see that there has been a variety of ways in which authors have rendered what has been commonly referred to as the team concept. Moreover, an historical approach to the topic reveals that these discussions emerged at fairly distinct periods in time, though writings on each of these types of teams has continued to the present. Authors have variously translated the concept into general practice teams (since the early 1920s), hospital teams (since the 1930s), nursing teams and psychiatric teams (since the late 1940s), rehabilitation teams (since the early 1950s), and home, community health and executive teams (since the mid-1960s). Further, since the late 1960s, some authors have interpreted the team concept in condition- or population-

specific terms, while others have claimed that the health care team is a fiction or a myth. Finally, some authors have occasionally seen the team as a multi-agency entity, or as the health care system as a whole.

B. National Differences

One of the most noticeable national differences in the writings on health care teams is a historical one. The first reports of teams being used in health care were from U.S. centres, with writings from Canada and Britain not appearing until well into the 1960s.

Thus, many of the centres of writing have been in the U.S., which has been, by far, the source nation for team concept discussions. The contributions to the nursing team discussions of the late 1940s and early 1950s were usually submitted by authors from the New York State and Chicago. Articles on psychiatric teams were identified with the Menninger Clinic in Topeka, Kansas--either because of the affiliation of the authors (Hutt, Menninger and O'Keefe 1947; Modlin and Faris 1954, 1956; Modlin, Gardner and Faris 1958), or because the clinic was seen as a model for how teamwork should be conducted (Peplau 1953).

Two connected centres in New York, the Dr. Martin Luther King Jr. Health Centre (MLK) and Montefiore Hospital, contributed, or were seen as contributing, considerably to the development of the community health team concept. Both Silver and Stiber (Silver 1958; Silver and Stiber) and Field (1955)

were associated with the Montefiore at the time of their publication. Some years later, the director at MLK, Harold Wise (1972) reported that the health centre was partly based on the earlier work at the Montefiore, including that of Silver. Later still, Tichy (1974) reported that the MLK was responsible for the creation of the Institute for Health Team Development, again at the Montefiore.

Tichy, a project historian for the Institute, wrote that the MLK was "one of the centres which successfully developed this [the team] approach" (1974:vi). As for the Institute itself, Tichy said that it had "as its core mission the eventual acceptance of the [team] concept by a wide range of health care services" including "the dissemination of knowledge on teams from both the medical and behavioral science literature (ibid.). Both the MLK and the Montefiore appear frequently in the writings, either as an author affiliation (Wise 1972) as a subject for papers (Beckhard 1972; Rubin and Beckhard 1972) or in the references of others. (Beloff's studies at Yale University's Family Health Centre [Beloff and Willet 1968; Beloff and Korper 1972] are also frequently cited.)

Discussions of the team concept in the U.S. have also been more diverse than those from either Canada or Britain. Writings in these latter two countries have been limited to teamwork in clinic settings and especially community health teams, and there is no mention of hospital teams in the

British articles. This is consistent with the fact that journal writings from Canada or Britain did not appear until the mid-1960s, at a time when U.S. writers were predominantly concerned with the community health teams.[20]

The British literature includes a theme not noticed in the writings from the U.S. or Canada. Many British articles--including the above-cited documents, and later articles by Corney (1980, 1983) and Corney and Bowen (1980)--associated the team concept with the idea of general practice "attachment" schemes. In these attachment schemes, a general practitioner would be supported by an attached or auxiliary staff, usually including a (district) nursing sister and a health visitor, in newly established premises (e.g., Hasler et al. 1968). In some cases, the team was extended to include social workers and midwives or even professionals outside the premises (Anderson 1969).[21]

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[20]The earliest British writings were by Fry, Dillane and Connolly (1965), Thornton (1966), two unsigned articles (Unsigned 1965, 1969), and two articles by Hasler and associates (Hasler 1968; Hasler et al. 1968). In Canada, writings came from Menzies (1965), Baumgart (1968), McCreary (1968), and Johnston, Cummings and Pooler (1968). Despite a sincere effort to reconstruct the literature on this subject, I have been unable to locate earlier documents from either of these countries.

[21]According to the early attachment authors, auxiliary staff were paid for from the general practitioner's income, who was also for their hiring and firing. By the late 1970s, these aspects of the practice had become much more complex, as attached workers became responsible to the local authorities of the Department of Health and Social Security. These changes providing a source for some of the later debates (see Appleyard and Maden (1979), and replies by Pastor (1980), Dick (1980) and Beven et al. (1980).

In the British articles of the late 1960s, most authors used "attachment" and "team" interchangeably. However, with arguments resembling the team-as-fiction authors, some later British publications (e.g., Brooks 1973; McClure 1984) have insisted that the attachment and team concepts are not the same. A clearer understanding of the arguments of both the team-as-fiction authors and the critics of those who equated attachment with the team concept must await a better awareness of what such authors have seen as the underlying philosophy, issues and practice of teamwork. For as with most other authors the critics of attachment and the team-as-fiction writers have assumed that health care team and teamwork in health care are inseparable, and their scepticism or criticisms have flowed from the claim that, since teamwork does not exist, nor does the team (or that a team is different from an attachment).

Indeed, when offering a general definition of a team, most authors said that it was a group of people working together for a common goal, and proceeded to describe the processes of teamwork. Thus, it is appropriate at this point to turn to a discussion of the ways in which teamwork has been constructed in health care.

IV. RATIONALES FOR THE "TEAM" CONCEPT

Throughout the history of the "team" concept writings, a number of explanations or rationales have been offered for its existence or necessity. In fact, many of the claims which will be discussed below have referred or alluded to these rationales. Thus, in order to provide an appropriate interpretive context for teamwork claims, I offer in this chapter a brief discussion of these rationales. In the latter part of this chapter, I present the claims of those who have recently called into question these rationales. In this outline, I concentrate on rationales which have been given for the team concept as a whole, leaving an account of the rationales for specific teamwork philosophies or practices for later. Also, it should be added that, though I deal separately with these rationales, team concept authors have typically seen them as being interrelated, and I have tried to convey this sense in what follows.

One of the most widespread and enduring arguments for the necessity of a team approach has been concerned with the shortage of professionally trained personnel or, conversely, an increased patient-need. For example, Hutt, Menninger and O'Keefe's post-world war two account of the team concept said that "its development and culmination were greatly fostered by

the needs of our vast army for psychiatric care. . . . There were simply not enough well-trained psychiatrists, clinical psychologists, and psychiatric social workers to deal with the problems" (1947:105). Similar supply-and-demand arguments have been advanced since that time, with all authors, claiming that the team approach provides more economical health care, either directly in overall cost or by using fewer higher trained professionals. The large numbers of authors who have advanced this claim might suggest that economics have been universally seen as a major reason for the introduction of the team concept. However, for the most part, it has been a claim made by or about U.S. physicians (Beloff and Korper 1972; Beloff and Willet 1968; Cairn and Kahn 1971; Carter 1966; Grieff and McDonald 1973; Jabitsky 1988; Schreckenberger 1970; Weinberger and Gay 1949) and U.S. nurses (Bates and Kern 1967; Brackett 1953; Carberry 1953; Igmire and Blansfield 1967; Jones and Ellsworth 1949; Struve and Lindblad 1949).

One of the first claims for a team approach (Barker 1922) was based on the belief that the process of specialization had necessitated the support of, and coordination of information between, specialists in order for the general practitioner to provide health care.[22] Many later writers have echoed what

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[22]In advancing this kind of argument, authors have occasionally made reference to writings of a sociological nature, e.g., Barker's (1922) citing Marshall's Readings in Industrial Society, published in 1920, or Silver's (1953) drawing on the works of Parsons and C. Wright Mill (cf. Crombie 1970).

might be succinctly called the "individual insufficiency thesis". In fact, this thesis has been employed by authors from a variety of professions, including nursing (Brunetto and Birk 1972; Carberry 1952; Rogers 1932), medicine (Ackerly 1947; Bernard and Ishiyama 1960; Crombie 1970; Magraw 1968; Silver 1958; Thornton 1966; Tietz and Grotjahn 1951) and social work (Connery 1951).

As a third type of rationale, many claims have been advanced to the effect that there is something peculiar about modern health care which requires a team approach. In fact, authors have frequently contrasted "traditional" and "team" approaches. There are several forms of this general argument which merit mentioning.

In one form of this claim, non-medical authors have referred generally to 'the times' (my words). For example, Rogers (1932), referring to nurse-doctor teamwork in the hospital, argued "it is unthinkable to consider the two departments as returning to the medieval and unintelligent relationship of subservience one to the other" (p.657). Some years later, writing on the rehabilitation team, Whitehouse (1951) would say that "teamwork today has become a fashionable term. We hear of teamwork in industry, science, community action, medicine, education, rehabilitation, and in almost every endeavour where men work together for mutual goals

(p.45)".[23] Again in 1970, Luther Christman, writing about the education of the health team, argued that "the current surge of activism" in society was showing a spillover effect in the health care students' attitudes, for "they too are challenging the establishment" (1970:285; cf. Baumgart 1968). An unsigned article in the 1970 volume of Hospitals more simply referred to "a time for a team" (Unsigned 1970). More recently, Bottoms (1980) has argued that

> at this point in the development of what could accurately be called the health team movement, it would be moot to argue for a team approach to health care. . . . it is a 'given' that health teams are here, and here to stay for many years to come (1980:106).

Thus, though individual authors have specifically referred to the time of their writing, claims of this sort have appeared throughout the history of the team concept.

Another version of the modernization argument for the team concept consists of what Nagi (1975:76) has called "an expanding scope for the concept of 'health'." Essentially what authors have intended by this is a modern recognition that illness or health is influenced by many different factors--usually reduced to physiological, social, and psychological causes--and that only a team approach can adequately address health care in this context (Ackerly 1947; Barker 1922; Baumgart 1968; Bernard and Ishiyama 1960; George,

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[23]As a specific form of "the times" rationale, authors like Whitehouse have frequently referred to other types of organizations which are using a team approach (cf. McDougall and Taylor 1978).

Ide and Vambery 1971; Modlin and Faris 1956; Bottom 1980). For some authors (e.g., Ackerly 1947), these new conceptions of health have been directly linked to the growth of knowledge, which has, in turn, been connected to the process of specialization. Most have also pointed to the conflict between these new conceptions of health and the process of specialization which has been partly responsible for them, claiming that this is further evidence of the need for a health care team. Once again, this is rationale which does not show professional differences.

Yet another rationale for the team concept, closely related to the specialization argument, has been the growth of non-medical health care professions in terms of improved education or increased status. For example, Silver and Stiber (1957:324) argued that the health team has become possible in part because of "the growth of social worker and public health nursing as professions". Similarly favourable remarks were made by Menzies (1965) regarding public health nurses' education and status, and Magraw (1968) regarding the status of all the newly emerging professions. Indeed, Magraw, a physician working with the Bureau of Health Services in Maryland, suggested that the professional growth of non-medical professions is something to be encouraged, not to be resisted which he says his colleagues often do.

A final type of rationale for implementing a team approach has been its official recognition, either by

professional or by government bodies. Arguments of this type have been advanced since the mid-1960s. For example, Topf and Byers (1969) refer to a Joint Commission on Mental Health and Illness report which recommended the use of a team approach. Similarly, writing in Britain, Brooks (1973) cites several British Medical Association reports, including those of a Working Party on Primary Medical Care and a Standing Medical Advisory Committee on the Organization of Group Practice (cf. Bowling 1983). In these types of claims there is a national difference: Although American authors have often used professional association reports to support their claims regarding the team concept, government reports have been used primarily in Canada and Britain.[24]

For most of the history of the team concept, these rationales have gone essentially unchallenged, though they may have not been made in all places and times. However, beginning in the mid-1970s, some writers began to express doubts about the necessity of a team approach. Nagi (1975) seemed non-committal regarding the individual insufficiency thesis, only acknowledging that it had been advanced as a rationale by others (cf. Temkin-Greener 1983). Much more explicit doubts have been expressed since Nagi's article,

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[24]See, for example the critique by Appleyard and Maden (1979) and replies by Pastor (1980), Dick (1980) and Beven et al. (1980), as well as the brief debate between Henderson (1981a, 1981b) and Godfrey (1981). For an exception to my generalization about nations, see Favis' (1978) critique of a New York state law regarding decision-making on psychiatric teams.

particularly by physicians. For instance, among their twelve questions about the team concept in health care, Walter Spitzer (a Canadian physician) and Rosemary Roberts (an Australian medical records worker) seriously questioned whether there was anything peculiar to modern health care which rendered the individual practitioner so inadequate that a team approach was necessary (Spitzer and Roberts 1980). As had Nagi before, Spitzer and Roberts merely viewed the individual insufficiency thesis as an untested assumption of team concept proponents. A slightly later critique by Brian Henderson (1981a), the coordinator for the Canadian Medical Association's committee on allied health, was more temperate: While he did not fully reject the individual insufficiency thesis, he did dispute the rationale of professional growth, saying that the development of new allied health professions was not grounds for including them on the health care delivery team; if anything, he says, this development has been detrimental to patient welfare.[25] Finally, Appleyard and Maden (1979), a children's physician and a psychiatrist,

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[25]The problem for Henderson (1982), is not so much whether there should be a health care delivery team--a plan, he says, which "needs a push"--but rather what medicine's position is vis à vis the government, regarding which professionals are really necessary for the team. In an interesting exchange, Godfrey (1981), a physiatrist, challenged Henderson's earlier arguments by suggesting that the latter was placing personal or professional interests above patient welfare. In reply, Henderson acknowledged that professional interest was a factor in his position, but "that physician leadership of the health care team requires that the medical profession articulate and support medical perspectives on the individual existing and emerging health-related occupations" (1981b:1258).

questioned the argument of official recognition, specifically the official recognition by Britain's Department of Health and Social Security and National Health service, denying that their opinions carried any weight at all in supporting the team concept.

These, then, have been the major debates surrounding the necessity or non-necessity of a team approach to health care. With this outline in mind, it is to an account of the specific claims about health care teamwork which I now turn.

V. A HISTORY OF "TEAMWORK"

To this point, I have presented a history of the types of health care teams authors have reported and the rationales they have offered for a team approach. In this chapter, I offer a historical account of the claims which have been advanced regarding teamwork itself.

I have divided the history of claims about teamwork into four rough stages. In the first stage, from the early 1920s to the early 1950s, authors raised many of the basic teamwork themes and issues which would appear in later writings. In the second period, from the middle of the 1950s to the middle of the 1960s, authors introduced the notions of flexibility and adaptability in teamwork and discussed the idea or goal of an integrated team. In the third era, from the late 1960s to the middle of the 1970s, authors developed earlier claims of egalitarian or competence-based leadership, the claims of the need for attention to group dynamics, and the claims of a need for educational reform. In the final period, several schools of thought about the team concept emerged: (1)positive claims that the team approach is a real and viable method of providing health care; (2)that teamwork is desirable, but that the health care team is a myth; (3)that the team approach actually occurs, but that its desirability is debatable; and

(4)that teamwork presents inherent dangers. To be sure, there is some overlap between these stages and even differences within them. Still, as this account will show, these stages do serve a useful heuristic or organizational purpose, as there is also a certain coherence to the discussions within each historical phase. In the conclusion of each section, I discuss the differences in the claims which had been advanced during that period, with reference to professional or geographical origins of the claims.

A. "Ancient History": Early 1920s to Early 1950s

In his address to the Yorkville Medical Society in New York City, Lewellys Barker (1922) argued that teamwork in the clinic involved a coordination of the efforts of medical specialists and the general practitioner, in order to provide a general diagnostic survey which would diagnose "the patient as a whole, with full consideration of all the somatic, psychic and social elements concerned" (1922:776). It had long been realized, Barker said, that specialization had rendered many medical personnel helpless to arrive at this "whole patient" diagnosis, and that consultation between specialists and general practitioners was essential. But, in his view, these consultations had been employed in a disorganized fashion. Taking his cue from then-current writings in industrial organization, Barker proposed that, by a team approach, specialist workers could be "linked up into organizations that will produce complete services adequately

controlled, instead of partial services indiscriminately rendered" (ibid.). For this teamwork to be effective, though, there was a need for new kinds of workers:

> Strange as it may seem, this remedy for the evils of an increasingly incoherent specialization has involved the development of new specialists, namely, (1)specialists in team organization, (2)specialists in team management, and, by far the most important, (3)specialists in the integration of the collected results of diagnostic studies made by members of the teams (1922:777).

Throughout Barker's address, and consistent with his industrial-organizational focus, the themes of coordination, control, management and integration of diagnostic information frequently recur.

Speculating on the future of teamwork, Barker noted that many of his colleagues had resisted a team approach, pointing out the difficulties of working out financial arrangements between team members, the danger of group practice leading to "state medicine", the tendency of group practice toward impersonality, and the inapplicability of industrial forms of management for providing personal services. However others, he said, had expressed enthusiasm for teamwork, foreseeing the day when all health care would be provided by this means. In conclusion, Barker asserted that "all such discussions of the probable future of group practice are more or less academic in nature. Teamwork in practice seems, at present, to be serving a useful function and to be extending" (1922:779).

In contrast to Barker's industrial-organizational approach, a different conception of teamwork emerged in

Dorothy Rogers' presentation to the Hospital Superintendents' Round Table at a 1932 National Nursing Organizations' convention in Texas. In her address, Rogers compared teamwork in a hospital to a game:

> "Teamwork" implies certain axiomatic conditions: Organization of the team for the purposes of a game, supposedly with an element of competition--a captain and players selected for their particular ability, a reward commensurate with the dictates of good sportsmanship. The hospital "game" presents the challenge of adequate, intelligent care of the patient, safeguarding the health of the community and making real contribution to the accumulated knowledge of medicine and its allied fields (1932:657).

Rogers also alluded to the individual insufficiency thesis, saying that "the game depends upon no player considering himself the sole performer or failing to recognize the ability of each member of the team to fill his post with skill and precision" (p.659). And, in working together, teamwork involved the communication between "the players". For example, Rogers argued that often no use is made of the nursing department's observations of ward equipment.

Finally, Rogers raised the issue of the captaincy of the team. To her, the captain of the team need not come from any particular profession: "it may be the superintendent of the hospital or of the nursing service, it may be the dietitian, the director of the laboratory and x-ray, the chiefs of medical staff, it may be the personnel in charge of departments within departments such as head nurses and supervisors, research appointees, departmental managers."

What was more important, Rogers claimed, was that leadership responsibilities were competently carried out. Teamwork, for Rogers, was a modern approach to hospital care, and therefore a cooperative venture. Specifically referring to the teamwork between medicine and nursing, she said, "it is unthinkable to consider these two departments as returning to the medieval and unintelligent relationship of subservience one to the other" (1932:659). Rogers's concerns of communication, the recognition of expertise, leadership and cooperation were to play central roles in future discussions of teamwork.

Indeed, Spafford Ackerly made the recognition of non-medical expertise a major theme in his 1947 presidential address to the American Orthopsychiatric Association. Himself a physician, Ackerly praised what he saw as "a healthy breaking down of departmental lines" in medicine, adding that

> This is true not only of the psychiatrist and the psychologist . . . but also of the social worker, for medicine is now poignantly aware of its past deficiencies in overlooking the social implications of illness. (1947:193)

Like Barker before him, Ackerly also claimed that teamwork required someone to integrate the various kinds of knowledge involved in diagnosis and therapy. For "the future growth of the team rests in its potentialities for the effective integration of knowledge in our own and related fields. The strength of the team lies in the checks and balances inherent in its very composition" (1947:195). And, like Rogers, Ackerly believed that effective teamwork necessitated a

democratic climate: "Psychiatry flourishes in a democracy. Nowhere is the principle of self realization more consciously practised through freedom of choice, self-motivation and self-direction than in the psychiatric clinic of today" (ibid.).

Other orthopsychiatric writings, published in the pages of Mental Hygiene in the late 1940s and early 1950s, echoed the importance of recognizing the expertise of other non-medical professions for the purposes of preventive care. This was the case for two papers presented at the annual meeting of The National Committee for Mental Hygiene in 1948, Elizabeth Fox's "Teamwork for the Young Child" and Alice Keliher's "Teamwork for Maturity". (Both papers were published together in the 1949 volume of Mental Hygiene.) In her presentation, Fox discussed the importance of the public health nurse on an orthopsychiatric team which also included a paediatrician and an obstetrician, in giving preventive child-rearing counselling to parents. It is clear, Fox said

> [that] each has a valuable contribution to make; that to make the most of these opportunities, the three must work together as a team, reinforcing each other in every possible way, that this calls for a mutual respect for and confidence in one another, for intimate knowledge of one another's functions, philosophies and procedures and for direct interchange concerning individual patients (1949:220).

Similarly, Keliher argued that it was crucial to pool the resources of the school, community and industry in screening young people for proper vocational choices. This screening was important for health, Keliher argued, for "we do not know

statistically how many of our large number of emotionally ill people were misfits in their jobs--made poor and inadequate life choices" (1949:234).

The recognition of expertise theme arose again in Robert Gluckman's argument that the chaplain constituted an important part of the orthopsychiatric team (Gluckman 1953). A psychiatrist at the Illinois Training School for Boys, Gluckman devoted considerable space to arguing why the chaplain was essential for psychiatric teamwork, and particularly the early diagnosis of boys' problems. According to Gluckman, chaplains were increasingly receiving scientific training in psychiatry. Moreover, according to Gluckman, the clinical and administrative staff at the school felt that including the chaplain's insights would result in "a more complete understanding of each case than that obtained by means of the traditional diagnostic procedure" (1953:279). Referring also to the theme of democracy, Gluckman attributed much of the success of expanding the team to "the fact that it was not an innovation initiated by the administration and forced upon the regular clinic members," but fully discussed "by all key clinic and administrative personnel and was unanimously agreed upon before instituted" (ibid.).

In contrast to its prominence in the orthopsychiatric writings, the theme of democracy was notably played down in the early discussions of the general psychiatric teams. Writing of neuropsychiatric teamwork in the U.S. army, Hutt,

Menninger and O'Keefe (1949) indicated that there was some leeway when deciding upon positions of team leadership. According to these authors, the leader of the teams they witnessed had been the psychiatrist, by directive of the war department. However, given the insufficiency of the individual professional for adequate treatment and the consequent need to recognize expertise, the psychiatrist's leadership position did not imply a rigidly superordinate position:

> There need be no question of subordinate position if each is permitted to contribute to the maximum of his capacities and is respected for that contribution as a co-worker in the total reconditioning process of the patient (1949:110).

The main responsibility of the psychiatrist was to summarize and integrate all the patient's data, gathered in informal conferences "in which the spirit of free 'give and take' prevailed" (1949:111). Moreover, the authors noted that

> in some circumstances, the director of the team might readily--and even more effectively -be someone other than the psychiatrist. . . . But whenever the focus is the psychiatric maladjustment of the individual . . . the psychiatrist or neuropsychiatrist is the individual thus to be designated (1949:118-119).

For Hutt, Menninger and O'Keefe, then, although teamwork required a certain flexibility in leadership, leadership would be assigned to the psychiatrist in cases of psychiatric disorders.

Such flexibility was not emphasized, however, in the other early discussions of general psychiatric teams, by

Weinberger and Gay (1949), Connery (1951) and Tietz and Grotjahn (1951). For these writers, the issue of who would be the leader of the team was never discussed; it was assumed that it would be the psychiatrist. In fact, for this reason, Connery (1951) and Tietz and Grotjahn (1951) saw the psychiatrist's therapeutic orientation as crucial for the process and outcome of teamwork. All three papers acknowledged that there were problems with this approach, and often phrased these problems in psychiatric terms. For example, Connery, a non-physician professor of psychiatric social work, linked the problems social workers had in working under psychiatrists to unresolved sibling rivalries (1951:84-88). Tietz and Grotjahn, themselves both psychiatrists, noted that the non-psychiatric therapist on the team "must have worked out his own problems with authority, so that so that he does not reject consultation and supervision" (1951:1058). (This psychiatric view of teamwork would re-emerge in future discussions of the team concept.)

Nor was the team leadership issue a major issue for the many discussions of nursing teams in the late forties and early fifties (Berger and Johnson 1949; Brackett 1953; Calabrese et al. 1953; Carberry 1952; Jones and Ellsworth 1949; Kuntz and Rogers 1950; Struve and Lindblad 1949). In all these papers, teamwork was described in terms of

centralization, planning, delegation, and supervision.[26] Most often rationalized by referring to the shortage of professionally trained nurses, the major concern--and the most frequently reported result of--team nursing was the conservation of highly valued professional resources.[27] Teamwork in this context consisted of the head nurse delegating some supervisory duties to the team leader (a graduate or advanced student nurse), and the team leader delegating some caregiving responsibilities to the nurses' aides. The process of creating nursing teams usually also involved making the teams responsible for a specific section of the hospital or a specific group of patients. Especially in the latter case, the planning of team assignments entailed holding conferences during the shift and the use of nursing care cards which listed patients and the team members responsible for them (esp. Jones and Ellsworth 1949; Kuntz and Rogers 1950).

Some of the most frequently reported benefits of a nursing team approach were a greater efficiency, more effective and comprehensive care of the patients, and the conservation of professional resources (e.g., by nurses

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[26]Talk of democracy appeared periodically, but this was limited to democracy between the nursing department and the hospital, rather than democracy between team members (see, e.g., Carberry 1952:73).

[27]In making this argument, several of the nursing team papers referred to E.L. Brown's Nursing for the Future, published in 1948.

performing mainly those tasks for which they had been trained). Several authors reported that these experiments in a team approach to nursing care had been accepted by the patients, the doctors, or the hospital administration (Berger and Johnson 1949; Calabrese et al. 1953; Struve and Lindblad 1949). Some nursing team authors also discussed patient safety, which they claimed was not violated by the delegation of professional duties (e.g., Jones and Ellsworth 1949).

In spite of the differences between the discussions of nursing and general psychiatric teams, there were also two commonalities. Both the nursing and psychiatric authors emphasized a need for "role differentiation" (i.e., an insistence that formal and traditional boundaries of tasks and responsibilities would be adhered to). For example, in discussing the use of the social worker and psychiatrist as an intake team, Weinberger and Gay noted that "there are differences in kind between the social worker and the psychiatrist. . . . we do not subscribe to the idea that the social worker should assume the responsibility for the psychiatric evaluation of patients" (1949:384). Tietz and Grotjahn, argued that psychiatric leadership on the team had the benefit that "the psychologist or social worker handling a patient in psychotherapy will not misunderstand his role and feel that he can establish a private practice in psychiatry" (1951:1058). Similarly, in reporting their experiment in team nursing assignment, Struve and Lindblad added that "to our

knowledge, there have been no instances of nursing aides leaving our services and posing or being employed as practical or professional nurses in the community" (1949:10). However, reporting on the same experiment a year later, Kuntz and Rogers noted that

> our doctors have not always understood that aides are allowed to perform only certain activities. They have sometimes asked nursing aides to assist them with procedures or treatments for which the aides have not been trained, and on the other hand they have asked nurses, who were busy with important duties, for assistance which an aide could have given (1950:528-529).

Finally, Brackett, in her review of Dorothy Perkins's book, The Team Plan, expressed scepticism whether Perkins was not "a bit overconfident in the ability of so many different types of personnel to be leaders" (1953:608).

As a second commonality between the writings on nursing and psychiatric teams, authors often listed professional growth as one benefit of the team approach. For psychiatric writers (and especially those who saw themselves in the orthopsychiatric tradition), the benefit was mutual, with all members of the team growing in knowledge, skill, or stature (Ackerly 1947; Hutt, Menninger and O'Keefe 1947; Weinberger and Gay 1949). In the case of the nursing team authors, this benefit of teamwork was usually reported with reference to the professional nurses, usually alluding to their improved leadership skills and the fact that they were able to exercise their expertise under a team plan.

Thus, to the early 1950s, many themes had been raised in the discussions of teamwork. Generally speaking, authors claimed that teamwork entailed the sharing, coordination and integration of information; planning, supervision and leadership; the recognition of expertise; and the need for role differentiation. Also, generally speaking, authors reported that teamwork resulted in a more holistic, integrated and effective diagnosis or treatment of the patient, which recognized the social and psychological causes and implications of health or illness. There were also claims that working as a team led to professional growth. These claims about the nature and results of teamwork would form the bedrock of later discussions, though they also would be transformed as new issues and claims emerged.

In addition, several professional differences emerged in these early discussions. Physicians most often claimed that teamwork entailed coordination, information sharing and role differentiation under physician leadership, while non-medical writers more often spoke of communication and the recognition of expertise in a democratic climate. However, there were even differences within these professional views, depending upon the specific team type being discussed. For one, nurse authors specifically writing on nursing teams did not discuss democratic climate and viewed nursing teamwork as requiring a clear differentiation of roles, a characterization more similar to psychiatric authors addressing general psychiatric

teams than to their nursing counterparts discussing teamwork in contexts involving non-nursing professions. Also, those psychiatric authors allying themselves with the orthopsychiatric tradition more often discussed teamwork in terms of recognizing expertise and working democratically, making their discussions more like non-medical writers than like other physician authors of this period.

B. "Middle Ages": Mid-1950s to Mid-1960s

In the second phase of the history of the discussions of teamwork, many of the themes which had emerged in the first period continued. However, the nature of the discussions did change. Perhaps the most noticeable change was that authors of this period more often presented teamwork as a flexible, dynamic or adaptive process, in contrast to the earlier authors' depiction of teamwork as a structured approach to care. Further, initiators of this general motif of flexibility claimed that it had consequences for other aspects of the team concept.

For example, Arthur Drew of the University of Michigan Medical School, adopted a philosophy of flexibility in his discussion of medical-social teamwork and "total patient care" (Drew 1953). Drew distinguished between two types of team situations. In the first, Drew argued, the team is concerned with a specific disease or condition (e.g., the paraplegic unit) and the composition and goals of the team are fixed and

clear. However, because of many patients' changing needs, the second type of team is flexible in its <u>composition</u>; indeed

> for the remainder of the patient's life innumerable medical and social work teams will be constantly formed and reformed. . . . It should be axiomatic that the needs of the patient determine the team rather than vice versa. Rigidity of teamwork structure more often than not defeats the basic purpose of such a routine (Drew 1953:27).

Another characterization of the psychiatric team as a flexible entity was offered both by Herbert Modlin and his associates at the Menninger Clinic and by Walter Lesser, of the Mental Hygiene Clinic of the Brooklyn Veterans Administration Office (Lesser 1955; Modlin and Faris 1954, 1956; Modlin, Gardner and Faris 1958). Lesser characterized teamwork as "A Dynamic Factor in Treatment"; Modlin and Faris (1956) wrote of "Group Adaptation and Integration in Psychiatric Team Practice". However, the discussions of psychiatric teamwork extended Drew's argument for the flexibility of team composition, applying this to the roles of team members as well. Lesser (1955), for instance, maintained that "consultation is the method by which team members continue to redefine their roles in carrying out their total treatment responsibilities" (Lesser 1955:125), a view which contrasted with the role-differentiation focus of earlier writers. Modlin and Faris, too, said that, at least in the early period of a psychiatric team's life, they observed "group structure built from a defining of roles, functions,

areas of competence, and a hierarchy of medical responsibility" (1956:98).

Role definition was also a prevalent theme in the rehabilitation team literature of this period. Frederick Whitehouse, director of vocational rehabilitation at the Institute for the Crippled and Disabled in New York claimed that "when functions are to be defined, the professional group must define them" (1953:143-144). Betty Caldwell also noted the broadening of role perceptions which comes from working as a team including a recognition of "role overlap", by which she meant recognizing common areas of functioning between professionals. (Caldwell also claimed that this role overlap is what makes team integration possible.)

Although many of the discussions of the role definition process referred generically to team members, several papers gave special attention to defining the role of the nurse. Minna Field, assistant to the chief of Social Medicine at Montefiore Hospital argued that the nurse's special contribution to the hospital team consisted in her more sustained direct contact with the patient and her acquaintance with the patient's family (Field 1955). Still, to make the most of the nurse's role, Field maintained that it was necessary for the nurse to constantly consult with the social worker and the physician. The Nursing Staff at the Veterans Administration Hospital in the Bronx discussed the role of the nurse in hospital, comparing it to the doctor's:

> Just as he [the doctor] identifies and diagnoses the medical problem, then plans and prescribes treatment, so does the nurse identify the nursing problem, then decides upon and develops a course of nursing action (1955:133)

In discussing the role of nursing staff in psychiatric teamwork, Peplau recommended the use of guidelines set forth in a Menninger Foundation report on Psychiatric Aide Education. According to Peplau, the report specified that

> the psychiatrist assumes total responsibility for the patient . . . [and] the psychiatrist's orders serve as a guide for the nursing department. . . . The work of the psychiatric aide is psychiatric nursing at a level administratively subordinate to that of the psychiatric nurse. In the future, the aide will belong to the nursing team . . . under the leadership of the psychiatrist (cited in Peplau 1953:91-92).

Last, Barbara Bates' research in the mid-1960s, both as a sole author and with M. Sue Kern, sought to define the nurse's role with respect to the physician (Bates 1966; Bates and Kern 1967). More specifically, they described their work as an attempt to define the "critical requirements for effective nurse-physician teamwork", from the point of view of each profession. According to Bates' first paper, published in Medical Care, this type of work was greatly needed, as "medical students often receive little orientation to the physician's role in relationship to other groups" (Bates 1966:69).

One of the means suggested for (re)defining team members' roles was by communication and attending to group processes and dynamics, especially in the context of team conferences.

In discussing psychiatric teamwork, for example, Lesser contended that "the degree of conscious application of team members to the problems of inter-relationships is the outstanding element in meaningful team functioning" (1955:126). This idea of the team monitoring its own activities would receive greater attention in the later discussions of teamwork.

Finally, in the late 1950s and early 1960s, the flexibility motif was applied to discussions of team leadership. Most articles from the first period of the history of teamwork had assumed that the leader of the team would be the physician. One exception was the paper by Hutt, Menninger and O'Keefe (1947), who had suggested that there was some flexibility in assigning leadership, depending upon the particular problems involved and the profession deemed as most competent. However, the issue of non-physician or democratic leadership took on a new life in the second period of teamwork writings. This was particularly true in the discussions of rehabilitation teamwork and especially in two papers by Frederick Whitehouse (1951, 1953). In "Teamwork--a Democracy of Professions" (1951), Whitehouse referred to the earlier philosophies of holism and flexibility in stating the three assumptions of teamwork:

> (1)The human organism is dynamic and is an interacting, integrated whole.
> (2)Treatment must be dynamic and fluid to keep pace with the changing person, and must consider all that person's needs.

> (3)Teamwork, an interacting partnership of professions specializing in these needs and dealing with the person as a whole, is a valid method for meeting these requirements (1951:45-46).

Since the patient problems themselves were in flux, Whitehouse maintained, team leadership must change with them in order for care to be effective. C.H. Patterson (1959), Associate Professor of Education at the University of Illinois, referred to Whitehouse's paper, in arguing that the team concept, as much as it implied a team captain, was obsolete. Instead, Patterson held that team decision-making should rely on "group-centered leadership" where "co-workers participate as equals in formulating and achieving group objectives. . . . Any and all members are leaders, each at the time when his contribution is important" (1959:10).

The theme of democratic leadership also emerged at this time in writings on nursing teams. In a jointly prepared paper from the Nursing Staff at the Veterans Administration Hospital in the Bronx, the authors contended that:

> Good leadership by the head nurse is essential for the successful functioning of all nursing teams within the unit. The example set by the head nurse who understands and applies democratic leadership is reflected in the democratic working of the team leaders, and, in turn, of the teams (1955:133).

Luther Christman and Ellowen Boyles, the director of nursing and the head nurse at Yankton State [Mental] Hospital in South Dakota, offered similar remarks in their report of an experiment in team nursing at the hospital. Referring to the morning planning conference, Christman and Boyles related that

> All members of the team were encouraged to take part in this group meeting. The team leaders became better acquainted with each staff member's personality and skill and could give closer supervision in a more democratic, acceptable way to the students and attendants (1956:54)

However, this democratic note was absent in the nursing team writings of the first period of teamwork writings and, as the later team nursing discussions would show, it was a temporary occurrence.

Authors addressing psychiatric teamwork in this period also discussed of the flexibility or democracy of team leadership. However, in this context, the ideas were less unanimously endorsed. For example, Sydney Bernard, the project director at Washtenaw County Department of Social Welfare, and Toaru Ishiyama, the acting director of the Department of Psychology at Cleveland State Hospital, drew a distinction between ascribed and achieved authority in teamwork (Bernard and Ishiyama 1960). They did not, however equate achieved or earned authority with teamwork; ascribed authority would continue to play an important part in the team approach. Indeed, according to Bernard and Ishiyama, the fact that authority can be derived both from abilities or drive and by virtue of being in a leadership position contributed to many of the status conflicts on the psychiatric team.[28]

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[28]In their discussion of status, role and motivation, Bernard and Ishiyama referred to several sociological sources, viz.: The Patient and the Mental Hospital, a 1957 collection of papers edited by M. Greenblat and D.J. Levinson; A.H. Stanton and M.S. Schwartz's The Mental Hospital (publ. 1954) and the work of R.H. Turner in role theory. Further, in their

In their review of psychiatric teams, Crawshaw and Key (1961) were also ambivalent regarding the arguments for democratic leadership. In their estimation,

> There is a great deal more popularity for democratic teams . . . than for autocratically run ones. The popularity stems more from cultural implications than any clear-cut proof that democratic teams do a better job. The autocratic extreme tends to stifle communication and increase rivalry, while the democratic tends to encourage anxiety, confusion and inefficiency, possibly to the loss of goals (1961:109).

Even the discussions of orthopsychiatric teamwork at this time (e.g., Matthews 1960) lacked the democratic overtones which characterized earlier literature on the topic. This view of psychiatric teamwork marked the beginning of a critical approach to the team concept, which would emerge more fully in the claims of later psychiatric authors.

Another leadership topic was discussed within the rehabilitations literature. In his 1953 paper, Whitehouse reiterated his earlier views of democratic team relations, but added the claim that effective teamwork required an autonomy of the team from the wider administration. According to Whitehouse,

> administration may make an ill-advised effort to lay down specific functional areas, which will result in a rope around the neck for individual ability. . . . When functions are to be defined,

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review of psychiatric teams, Crawshaw and Key (1961) argued that social scientists had contributed considerably to the development of the psychiatric team concept, especially by carrying out small group research. Indeed, references to works of a social scientific nature had been, and continued to be, quite common in discussions of the team concept.

> the professional group must define them (1953:145-146).

This view, too, was shared by Patterson who argued that the team can function with no need for external supervision or control. While this claim was not especially prevalent in the discussions of this time, it was a view which would play a large part in later discussions of teamwork.

Another common theme during this period of the history of the team concept was the influence of team members' prior education, which was usually seen as a barrier to effective teamwork. In particular, Drew pointed to specialization in the education of medical and social work specialists.[29] This was especially true where communication between team members was concerned. "All too often the various specialists are virtually unable to communicate their highly technical understanding of the patient to each other" (1953:29). Silver and Stiber (1957), too, noted the barriers to communication in medical-social work teamwork and added that there is a need for additional in-service education training.

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[29]Drew cited Barker's 1922 address which had also mentioned the problems associated with specialized education in medicine. However, Drew also argued that this problem of specialization in medicine had been recognized by novelist Tobias Smollett, writing in the mid-eighteenth century.

[30]Drew also mentioned that team members' professional education did not sufficiently emphasize a long-term or preventive approach to the patient. This theme of prevention, somewhat subdued here, would emerge more strongly in the discussions of community health teamwork of the late 1960s.

Similarly, Doris Taggart (1953), addressing the role of occupational therapy in the mental hospital, argued that most other professionals do not realize that work activities are therapy, and additional in-service education and greater communication between the professions involved were required to overcome this deficiency. Finally, Caldwell (1959) noted that members of the rehabilitation team tend to view the patient's problem in terms of profession-specific perspectives, derived from their professional educational experiences, though she believed it was possible for team members to find some common ground, again by communication.

Several authors linked this concern for educational bias with problems in integrating the members of the team during teamwork. Indeed, the general matter of integration occupied considerable space in the discussions of the team concept at this time. Articles from the previous period had argued that teamwork was necessary for an integrated analysis or view of the patient. What was new in the discussions of the second period, though, was the idea of integrating the members of the team or achieving an integrated team. Even those authors who had not discussed the problems of role-definition, group monitoring, or education of team members nonetheless had concerns of professional integration within the team (Field 1955). However, it was more often in the context of these other matters that the issue of team integration was raised.

For example, in his concern for the effects of specialist education Drew (1953) argued that specialized education and knowledge made the integration of medical and social work professionals very difficult. Similarly, Lesser, in arguing the value of consultation in monitoring the team's group processes added that consultation "is the coordinating and integrating force that runs through a successful team's operation, which in turn leads to a meaningful treatment experience for the patient" (1955:126).

The strongest proponents of integration, though, were Modlin and his associates, who saw integration as the culmination of the psychiatric team's maturation process. In the "change" stage of growth, they noted that

> A concept of the group as a functioning unit began to form. . . . The members began to see themselves and others less as individuals and more as agents of the team according to their suitability for the particular task, regardless of the discipline they represented (Modlin and Faris 1956:99-100).

Further, the authors reported that by the final stage of team growth a group identity had formed and, as the team developed tacit communication, problems of communication had largely disappeared. Finally, in a later paper, Modlin, Gardner and Faris (1958) further linked integration to a greater likelihood that patients followed the team's therapeutic recommendations.

Thus, in the transition from the first to the second period of teamwork history, the discussions of teamwork changed considerably. In contrast to earlier writers' claims

that teamwork involved a structured, planned approach, the keynotes for team concept authors in this second period were flexibility and adaptability--especially in terms of role-definition and leadership. In addition to the flexibility motif, authors expressed some concern for the negative influence of education on team functioning. Last, in this context, several authors raised the matter of integrating the team itself, rather than merely the integrated analysis mentioned by earlier authors.

As with the first period in the history of the team concept, there were professional differences in these later claims about what constituted teamwork, though these were not always along the same lines as professional differences in earlier times. Physicians continued to discuss teamwork in terms of information sharing, coordination and integration of analysis. One change in the discussions concerned nurse authors writing about teamwork on the nursing team. In this second period they often discussed such teamwork in terms of collaboration and democracy, which remained the way in which nurse authors discussed general teamwork in the hospital as well. Another change concerned the psychiatric writings. Discussions of the team concept in an orthopsychiatric setting were less frequent than in the earlier literature and, at the same time, they were not written with the same concern for democracy.

Finally, this period saw the emergence of writings on the rehabilitation team. Along with contributing to the discussions on flexible or democratic leadership within the team, rehabilitation team authors also raised the issue of the autonomy of the team, which would recur in later writings on teamwork.

C. "Renaissance": Late 1960s to Late 1970s

There are several reasons for seeing a new phase of writing on the team concept beginning in the late 1960s. First, there was apparently a substantial increase in the amount of writing on the topic. In particular, a number of contributions at this time came from professionals who either had not contributed to the earlier teamwork discussions, or who had only played a minor part in them. Second, as pointed out in my third chapter, the late 1960s marked the appearance of the first Canadian and British documents dealing with the team concept. Last, several new team forms were reported at this time. As the following section will show, there was a new character to the discussion of teamwork in these new contexts.[31]

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[31]I have indicated throughout this thesis, that this period saw a huge increase in the number of documents on teamwork, as well as an increase in the variety of team types, nations, and professionals involved. Consequently, I am only able to offer a beginning account of the many claims which were advanced during this time. In this section, I concentrate on those themes which were especially prevalent and those which were continuous either with what had been discussed before and what would be raised in later deliberations.

This third period of the history of the team concept might be seen as something of a "renaissance", at least as it applied to general health care teamwork in North America. Aside from the overall increase in the number of documents, the previous themes of egalitarianism and competency-based leadership, preventive health, communication, education, and team autonomy were given new life. Moreover, there was, in general, an optimism over the potential of teamwork. However, as the following section also will make clear, the motifs of the earlier discussions were reinterpreted to a large extent in this third period, and the optimism was not universally shared. In particular, the signs of criticism evident in the psychiatrists' claims about teamwork at the end of the 1950s were to increase in this third period, with many of their criticisms being directed at the newly revived motifs.

One specific change in the teamwork discussions of the late 1960s concerned the claims made about the nurse's role in health care, aimed a promoting the professional status of nurses.[12] For example, in 1967 the International Nursing Review published extracts from a presentation by Alice Girard, then-president of the International Council of Nurses. The presentation, given in 1966 at the Fifth Biennial Congress of the South African Nursing Association, carried the title Full

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[12]Some of these discussions vaguely refer to the "health team". Thus, to avoid misinterpretation, I have also kept my reference general. Where their reference to the team is clearer, I have specified it here.

Partner in the Health Team (Girard 1967). Girard was direct in her call for solidarity amongst nurses in their struggle for professional status:

> For some years, nurses in general were quite content with the role of angels of mercy, but the leaders who fought for official recognition through state registration and those who fought for the control of nursing knew that this was not the end, that they must go further. [T]hey had learned that it was only through collective effort that progress could be made on all fronts (Girard 1967:31-32).

In this "collective effort", Girard noted the need for research and education devoted to the professionalization of nursing.

In a similar vein, Peeples and Francis (1968) outlined several of the "social-psychological obstacles to effective health team practice"--and especially to effective nurse physician teamwork. The authors described their paper as an attempt to debunk the "popular but naive conception that human behaviour is largely random and if you wish to see behavioral change, you must change the hearts of individuals" (1968:28). Instead, Peeples and Francis claimed that "being prepared to recognize repeated acts as patterned behaviour gives the health professional the alternatives of purging social patterns which obstruct effective working relationships and reinforcing behaviour which serves to integrate and improve working relationships" (1968:29). According to Peeples and Francis, there were many social-psychological and structural biases working against nurses' contributions to teamwork, including differences between nurses and doctors in terms of

income, social class and status, sex segregation and sexual inequality, and prevalent beliefs that nursing care was less important for health than medical care for patient well-being.

Another call for nursing solidarity--this time in the context of the nursing team--did not share either Girard's egalitarian spirit or Peeples and Francis's critical claims about inequalities which nurses faced. The paper, submitted by Elaine Gordon, Patricia Adams and six unidentified students at the Sacremento City College in California, titled "You Can't be a Team by Yourself", was also published in the International Nursing Review. The authors urged "the immediate need for strengthening the bonds between all nurses. . . . by making all nurses aware of the attributes of team nursing" (Gordon and Adams 1971:77). In developing these bonds, Gordon and Adams and their coauthors argued the need for good communication, and the development of listening skills. In addition, they claimed that

> a successful team has a plan of action that provides an atmosphere of security for its members. We must draw lines of authority and define areas of responsibility well. Each nurse must be fully aware of her duty, her function as a member of the health team and her specific role in the team approach to patient centred care. This does not mean that authoritarian leadership must prevail, but rather, that boundaries be set so that team members are not asked to perform tasks beyond their capability. In this way the inner security and confidence of each individual is not threatened (Gordon and Adams 1971:77).

Three other papers on the nursing team reiterated these traditional emphases upon delegation, professional nurse

leadership and role-differentiation. For example, papers by Fosberg (1967) and Wicker (1970) report on the development of leadership education materials for nursing curriculum. The experiment reported by Brown and Roche (1966) is striking in its resemblance to those reported in the late forties and early fifties. Thus, the egalitarianism theme, which had appeared in the nursing team writings in the mid-1950s was no longer present, and the distinction between nurses' writings about general health care teamwork versus their writings about the nursing team had re-emerged.

Many other non-medical authors writing on teamwork on general health care teams in the late 1960s, though, claimed the need for egalitarian relations. One example was three jointly published papers which appeared in the 1968 volume of The Canadian Nurse under the general title, "Teammates are Equal Partners" (Johnston, Cummings and Pooler 1968). The articles were written by a social worker, an occupational therapist and a therapeutic dietitian, and dealt at length with the roles each played especially in hospital care. Directing their remarks to nurses working in the hospital setting, all three authors called for a better understanding of the importance of each other's work, mutual respect, and closer working relations between the professions. For example, Johnston (the social worker of the three), argued that the social worker's expertise was often underutilized:

> few hospitals or public health agencies make imaginative educational use of social workers to

> achieve greater ease of communication within nursing itself, between nursing and other professions, and with patients and their families (Johnston, Cummings and Pooler 1968:37).

Similarly, Cummings (the occupational therapist), held that "cooperative work by the doctor, nurse and occupational therapist, with respect for each other's profession and services can be of great value in the achievement of goals set for the mentally or physically handicapped patient" (ibid.:39). Finally Pooler (the dietitian) maintained that "in some instances, the patient's diet is not considered as important a part of nursing care as it might be and the dietitian's knowledge is not utilized to the advantage that it might be" (ibid.:40). Referring to the enduring theme of recognizing non-medical expertise, each of these authors argued that teamwork required a close working relationship between each of their professions, doctors and nurses.[13]

Johnston, Cummings and Pooler's emphases on communication and mutual understanding were keynotes in the contributions from non-medical authors of this time. At least as far as the sharing of information was concerned, communication had been a common theme in the discussions ever since Barker's original paper in 1922. In fact, information sharing was often the only topic discussed in the context of teamwork (e.g., Schreckenberger 1970; Zane 1965). However, the discussions of

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[13]For similar discussions of new roles on health care teams, and of the need for better communication and cooperation between the nurse and the new professionals, see Holmes (1972) and Jansen (1968).

the third period more often focused on communication about interprofessional relations and the team's process of working together. These later authors often regarded such communication as an essential feature of teamwork. In this way, their claims were reminiscent of those of earlier psychiatrists like Modlin and Faris (1956) and Bessel (1955), who had argued the need for the team to "monitor" its own activities.

Three later examples of this monitoring motif appeared in papers by Wise (1972), Igmire and Blansfield (1967) and Odhner (1970). (Wise is exceptional as he was the only medical author to treat this topic in any detail.) All these authors reported in-service educational programs aimed at improving teamwork relations and decision-making. Igmire and Blansfield and Odhner modelled their programs on the T-Group, which they claimed had been useful in other organizational contexts. Wise, on the other hand, related how several management science researchers, contracted from the Massachusetts Institute of Technology, conducted group-dynamics research at the Martin Luther King Health Centre in order to improve teamwork there.

Igmire, professor of Nursing at the San Francisco Medical Centre, and Blansfield, second vice-president of the National League for Nursing, reported on a series of sensitivity training conferences which they had conducted. According to the authors, the conferences took place outside the hospital

setting and were intended primarily for hospital executive team members. As Igmire and Blansfield described it, the program had the following objectives:

> (1)to acquire interpersonal, group, and organizational skills, (2)to gain insight into self, (3)to achieve greater staff involvement in planning, (4)to provide new ways of diagnosing problems of communication, motivation, and leadership patterns, and (5)to build more effective administrative teamwork (1967:385).

In addition to the general motif of monitoring, the theme of egalitarianism arose in this context as well. Indeed, it was often presupposed as a necessary element of teamwork. Igmire and Blansfield reported that one question addressed in the leadership conference was "How can the democratic process be used in making decisions without slowing down the decision-making too greatly?" (1967:391). Further, in a series of tables, Igmire and Blansfield noted many positive reported outcomes of teamwork including "improved meetings", "better problem-solving", "better communication with staff and peers", and "more respect for others" (Igmire and Blansfield 1967:396-397).

Fred Odhner, associate program analyst with the New York State Department of Mental Hygiene, reported his observations of a T-Group session and compared them to the allied health team, saying that in the team "members' expectations that the doctor will assume all responsibility may be so strong as to blind them to even his most insistent attempts to shed the omnipotent role." However, Odhner added that "we cannot

depend for direction upon the fantasies of omnipotent authority, nor evaluate each members' contributions according to the occupational status of the contributor; but rather we must evaluate each member's offerings only in terms of their relevance to task solution" (Odhner 1970:487). This idea of leadership based on a team member's competence or contribution also occupied much space in the discussions of teamwork at this time.

One context in which the new ideas of leadership flourished was that of community health care teamwork. Most noticeable in this respect were those claims about competence-based leadership which came from U.S. physicians. It may be recalled that, with the possible exception of the early psychiatrists associated with the orthopsychiatric tradition authors (e.g., Ackerly 1947; Hutt, Menninger and O'Ke[illegible] 1947), physicians had generally viewed the team as being physician-led. However, with the rise of discussions of community health teamwork, their ideas changed.

For instance, in his description of the Family Health Care Project at the Yale-New Haven Medical Centre, Jerome Beloff noted that, in community health care,

> The emphasis is centered on the patient or family health need, with the services of the most appropriate team member, rather than those of a fixed physician or his personally designated agent. Team leadership, therefore, varies according to the nature of the problem (Beloff and Willet 1968:75).

Similarly, Harold Wise, reporting on community health teams at the Martin Luther King Health Centre in New York, said "our

goal was to develop a task-oriented team where leadership shifted to the team member best prepared to carry out a particular task" (Wise 1972:443). Aradine and Hansen (1970), reporting on community health teams at the University of Wisconsin Family Health Service, added that the physician, nurse and family counsellor team members collaborated with each other as colleagues.

> We do not consider the physician to be the leader, director or decision-maker of all team activities. . . . For any family, the team's leader or coordinator may be nurse, physician or family counsellor. . . . Leadership is necessary, but varies according to the needs presented by families and may change over time as needs change. . . . A pragmatic and flexible approach is continually necessary (Aradine and Hansen 1970:214).

Thus, much like the rehabilitation teamwork claims of the mid-1950s, the view that the team should not be confined to physician leadership had been connected with the themes of flexibility and the recognition of the expertise or competence of all team members.

Claims about leadership or decision-making on community health teams also resembled the earlier rehabilitation writings in another way, for there was a re-emergence of the argument that teams should be autonomous units. As Wise (1972) described it, this was particularly the case at the Martin Luther King Centre. Wise reported that, on the basis of the work of the MIT School of Management research group

> An overall re-organization of the agency's structure is progressing, the primary thrust of which is to give authority to the health teams and

> provide them with more efficient backup services to do their job (Wise 1972:444).

Similar recommendations for greater team autonomy were presented in the reports of Rubin and Beckhard in back to back papers in the Milbank Memorial Fund Quarterly (Beckhard 1972; Rubin and Beckhard 1972).[4] The arguments for team autonomy made by Wise, Beckhard and Rubin paralleled those for task oriented leadership within the team itself. Since team members are closer to the problem than management, the team is better equipped to make decisions affecting team care.

Another theme which emerged in the discussions of community health teamwork, but which was raised in other contexts as well, was that of education. Specifically, Wise (1972) and Aradine and Hansen (1970), claimed that existing professional education did not prepare students for the reality of community health care teamwork. The chief deficiencies in formal education, they said, were a lack of training in working together and a lack of acquaintance with preventive approaches to medicine. All these authors recommended compensatory inservice re-education or an orientation to prepare arriving professionals for their new setting. For other community health team authors (e.g. Sifneos 1969), it was the experience of working as a team that was the remedy for what formal education lacked.

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[34]In their papers, Beckhard and Rubin refer to work done at a community health centre, which they do not name. Wise's paper, though, cites Beckhard and Rubin (among others) as part of the MIT research group.

Other papers appearing at the turn of the seventies also argued the deficiency of formal education, though these either argued that changes needed to be made to formal education itself (e.g., Carter 1966; Christman 1970) or reported having actually made such changes. With respect to the latter, one centre of contributions was the University of British Columbia. In an early paper, Alice Baumgart (1968) reported that the Health Sciences Centre being developed at the University would aim to provide common educational experiences for health care professionals from medicine and allied fields. In her paper, Baumgart also noted that one of the main forces behind the project was the Dean of Medicine at the University, John McCreary. In support of interdisciplinary education, Baumgart cited McCreary as saying

> "Teach them together, have them study together, take lectures together, eat together. Then they will develop some sympathy and understanding for what each discipline has to produce and be a health team in fact" (cited in Baumgart 1968:42).

McCreary published a separate report on the project two months after Baumgart's. In addition to describing the program, he noted that major problems were encountered in trying to establish it:

> The problems . . . are the same as those which face any major innovation. There are fears on the part of the medical faculty that the scientific content of their programs will be diluted by teaching other than medical or dental students. There are fears on the part of the allied health professions that they will lose their identity and be swallowed up by the monstrous medical establishment. . . . Perhaps the greatest single problem associated with the development of interprofessional education in

> the health sciences is the lack of the model (McCreary 1968:1554).

Finally, two years later, George Szasz--also of the faculty of medicine and director of the Office of Interprofessional Education in the Health Sciences at the University--provided an update on the project (Szasz 1970). As Szasz described it, the common educational experiences had come to include the joint diagnosis and reporting of cases as well as attending many common lectures. In his assessment of the project to the date of his writing, Szasz concluded:

> The students of one profession react positively to students of another profession in their classes, if they receive an explanation of the need to have common learning experiences; utilization of the problem-solving method in learning experiences appears to be the most promising means for development of co-operative relationships; and [there is] more general support from the health professional schools other than the medical school (Szasz 1970:390).

To my knowledge, this was the last report of the Health Sciences Centre's activities.

In addition to witnessing the first articles from Canada, the third period in the history of teamwork also saw the first discussions of teamwork by British authors, many of which appeared in the British Medical Journal. With the exception of Crombie's (1970) discussion of the domiciliary team, all of the British contributions from this time concerned teamwork in the context of community health teams which was also the subject of most North American papers.

However, there were two differences between the discussions of teams on the two continents. One difference was the absence of British discussions of educational reform, which were present in U.S. writings and very prevalent in the Canadian writings of the late sixties and early seventies. Some British authors, such as an unsigned paper appearing in 1969, argued that different educational backgrounds were one explanation for why teamwork had not taken root sooner, but there was no further discussion of the issue (Unsigned 1969).

Another difference between North American and British writings concerns the theme of leadership. At a time when North American (and particularly U.S.) authors were claiming that teamwork involves decision-making based on competence, no such discussions arose in the British literature. Although the recognition of competence and expertise is often present (e.g. Thornton 1966), teamwork is not described in the same terms as in the North American community health teams. For example, in their discussion of the development of the nursing section of a community health team in Sonning Common, Hasler and his co-authors related that

> the decision of whether the [nursing] sister makes a first or assessment visit rests with one of the doctors. All new requests for home visits are screened by the senior secretary . . . in consultation with the doctors. The doctors and sister then decide at a daily conference which cases are suitable for her, and she reports back later in the day to the doctor concerned. . . In this way much work that a doctor might otherwise have to do is coped with satisfactorily (Hasler et al. 1968:734).

Later, the authors added:

> We think attachment schemes as such are only halfway step, and that qualified nurses should develop in the way we have indicated, themselves delegating less important work where possible (ibid.:735).

Further, in an unsigned letter submitted to the British Medical Journal in 1965, the author claimed that teamwork "frequently demands a willingness to hand over some function to another member of the team" (Unsigned 1965:5). Finally, in describing the "new horizons in teamwork", J.L. Burn, a general practitioner at Salford, wrote that the work of the nurse team member was "releasing doctors to do the work which only they should or can do" (802). Thus, both in their emphasis upon the idea of delegating duties and in their focusing on the conservation of professional resources, the discussions of community health teams by these early British authors more closely resembled the American nursing team approach than the community health team approach as the latter was described by North American authors.

As a last major development in this third period, several authors writing on psychiatric teamwork began to critique the process. Many of these critical claims came from psychiatrists themselves and revolved around the themes of role-definition and leadership as they had been developed in the late fifties.

The only positive discussion of psychiatric teamwork at this time was a report of a study by Margaret Topf, of the

School of Nursing at UCLA and Ruth Byers, a community health consultant in the Golden State community Mental Health Centre in Pacoima, California (Topf and Byers 1969). According to the authors, a Joint Commission on Mental Illness and Health report had approved of the process of "role fusion" in community mental health teamwork, and their study aimed to discover whether or not this was taking place. Topt and Byers defined role fusion as "a similarity of tasks and expectations in two or more professions", justified both by the recognition of competence of non-medical professionals and by the Joint Commission report (ibid.:271). The authors claimed that, on the basis of job descriptions listed in journal articles, role fusion was becoming a reality.

In marked contrast, a critical paper by psychiatrists Quentin Rae-Grant and Donald Marcuse spoke of "The Hazards of Teamwork" (Rae-Grant and Marcuse 1967). The paper was a leading editorial in the American Journal of Orthopsychiatry. One particularly serious hazard, the authors argued, was a "blurring of roles". According to the authors,

> if egalitarian teamwork brings about sufficient blurring of roles, and if jobs are sufficiently undifferentiated, the full thrust of each member's clinical effectiveness is never felt. Diffused identities and diffused social structure breed anxiety that interferes with and undermines therapeutic work (1967:5).

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[35]Rae-Grant was a member of the editorial board of the American Journal of Orthopsychiatry. Marcuse was a researcher at the National Institute of Mental Health's Mental Health Study Center.

However, the authors added that the opposite extreme, an over-differentiation of roles, "is equally treacherous".

In a similar vein, Grieff and McDonald (1973), researchers at Syracuse Psychiatric Hospital in New York, claimed that role relationships between psychiatrists and non-medical team leaders were creating conflicts. Reporting research on team leaders and psychiatrists, Grieff and McDonald argued that there was evidence of role overlap on the team, with psychiatrists' roles being less well-defined than those of team leaders. Moreover, they claimed, the respective areas of competence of the two types of team members were often unclear, leading to disagreements about which team member was competent to make certain decisions.

The claims presented in the Rae-Grant and Marcuse and the Grieff and McDonald papers touched on another area of concern for psychiatric writings on teamwork: egalitarian or democratic relations within the team. A more direct critique along these lines, though, came from Bowen, Marler and Androes (1965) in their article, "The Psychiatric Team: Myth and Mystique". The authors (two social workers and a psychiatrist) said that the concept of teams as "democracies in miniature" is, in the extreme, absurd: "The notion of the majority determining a plan of action borders on the illogical, and possibly a perversion of professional roles, when carried into specific areas" (1965:687).

A final critical view of psychiatric teamwork came from Blackman, Silberstein and Goldstein (1965), three psychiatric professors and researchers, who reported status conflicts on interdisciplinary mental health teams. According to the authors, the growing status of professional psychologists (and, to a lesser extent, social workers) was creating dissatisfaction with the way psychiatric coordinators regarded psychologists' efforts. For example, they said, "psychologists may feel that testing is not sufficiently weighed in the team's diagnostic workup" (1965:578). According to the authors, the fact that psychologists were increasingly offered attractive options besides community mental health work was leading them to consider abandoning the field. Further, in the course of their critique, Bowen, Marler and Androes claimed that:

> The diagnostic team functions as a formal group and its status hierarchy is psychiatrist, psychologist, social worker. Although the use of the word "team" is an effort to deny this pecking order, the pecking order, the hierarchy still persists (1965:579).

The resemblance of their comments to the team-as-fiction claims which would emerge in the late 1970s is striking.

The era of teamwork history between the mid-1960s and the mid-1970s showed a remarkable diversity. Claims were advanced by professionals who, prior to this period, had played only a minor part (if any) in the discussions, such as social workers, physical therapists and dietitians in general health teamwork, and psychologists in psychiatric teamwork. Further,

claims of egalitarianism, professional expertise and competence-based leadership; the need for role definition, communication and monitoring of group dynamics; and the need for educational reform all emerged, either as new claims or, more often, as re-workings of previous themes.

As with earlier times, the nature of the claims in this third period differed according to their origin. For instance, there were again professional differences, though these were not always comparable to the ones of earlier times. Nurses writing on the nursing team no longer spoke of democracy, as their discussions resumed a character more like their earliest claims. With respect to general health care, though, nurses continued to claim that teamwork involved a recognition of expertise within an egalitarian framework and sought professional status or solidarity through the team approach. Other non-medical writers made similar claims.

Perhaps most noticeable, though, were the differences in the claims advanced by physicians. As with earlier times, there were differences within medicine. However, in this period, non-psychiatric physicians writing about community health teams took an approach similar to orthopsychiatric writers of the late forties, claiming that teamwork involved a recognition of expertise and egalitarian decision-making in the context of preventive health care. Some physicians claimed that a need for knowledge of preventive medicine and working relations required changes to education.

In contrast, claims advanced regarding psychiatric teams reflected a re-thinking of teamwork as it had been developed. In particular, authors claimed that egalitarianism and competence-based decision making and flexible role definition in psychiatric teamwork caused conflict and confusion. Most of those who opposed teamwork practice on these grounds were psychiatrists, but similar arguments were advanced by researchers and social workers.

Two geographical centres also emerged in this period. One was the Martin Luther King Centre, which was discussed in my third chapter. Another centre arose in Canada, which itself was only just emerging as a source for teamwork claims, at the University of British Columbia. Three of the papers which discussed educational reforms originated from the university, reporting the development of interprofessional educational experiences there. Britain, too, became a source of teamwork claims in the late sixties, though there were no particular prominent sources, and the discussions there differed from those in North America. For one thing, there were no claims in the British literature regarding educational reforms. For another, there were no claims concerning competence-based decision-making in the context of community health teams.

Finally, as I mentioned at the outset of this section, with the exception of claims about psychiatric teamwork, the

arguments of this period were typically optimistic. However, this optimism would not remain.

D. "Modernism": Late 1970s to Late 1980s

Up to the mid-1970s, then, the views of authors discussing teamwork were positive in a double sense. They were positive, first, in the sense of affirming the reality of teamwork (and health care teams). And, second, they were positive in the sense of seeing a team approach as a desirable way to provide health care. The same cannot be said of the claims made in this final period of the history of teamwork. To be sure, there continued to be substantial numbers of authors who advanced essentially positive claims, in much the same way as earlier authors had done or in reinterpreting earlier ideas in a positive fashion. However, there were also many writers who differed from what had been claimed before. For one thing, this final period saw a substantial number of sceptical claims. On the one hand, as was pointed out in my third chapter, some sceptics claimed that this team was a fiction or a myth. On the other hand, other sceptics questioned whether teamwork was, in fact, a superior way to provide health care. Yet other authors claimed that, if anything, teamwork presents certain dangers. Finally, some authors have made a combination of claims which cut across these types. In this section I give an account of these most recent claims, according to these loose "schools of thought".

A number of authors discussing teamwork over this period have remained positive. For example, two articles submitted at the beginning of this final period reported the use of the problem-oriented record (POR) system in a team approach to patient care. A earliest of these submissions, written by then Senior Nursing Editor of the journal MJ bore the title "The Problem Oriented Record: Uniting the Team for Total Care" (Robinson 1975). Robinson related that she had visited two facilities which used the POR system and offered her observations of the process. The later submission contributed by Lynn Beattie, head of the Division of Geriatric Medicine at the University of British Columbia, reported the use of the record system in a long-term care facility (Beattie and Crawshaw 1982).

According to all the authors discussing the POR, such systems are useful as teamwork tools because they aim to

> (1)make information easily understandable and accessible to all workers, by requiring that assessments are written by all team members in both behavioral and diagnostic terms,
> (2)make information relevant to patient centred care, by requiring that information is directly related to a patient problem; and
> (3)make records flexible, by requiring that old information is replaced by new information as care continues.

Both articles, then, developed the theme of communication, so widely discussed in the late sixties. Further, according to Robinson the use of the POR was, among other things, an educative process for team members:

> Physicians become aware of new problems, observations and nurses' assessments. They build their therapeutic plans with nurses' help, and they learn how effectively nurses can teach patients and carry out intelligent and independent nursing plans. Nurses learn the reasons for medical orders and how to assess their results. . . . Physicians and nurses learn how to work together in a genuine partnership to alleviate their patients' problems (Robinson 1975:25).

Beattie and Crawshaw, on the other hand, noted some difficulties in implementing the use of the POR. For instance, they reported that physicians were sceptical about the use of stating problems in behavioral terms, while other team members stated problems in vague terms. However, the authors add that these problems were largely overcome by creating a manual for using the POR and creating a POR coordinator position (Beattie and Crawshaw 1982).

Authors discussing the use of teamwork in rehabilitative care have also advanced positive claims. For example, Crisler and Settles (both staff of the Rehabilitation Counselor Training Program at the University of Georgia) reported the use of a team approach--based on the ideas of Whitehouse (1951) and Patterson (1959), among others--in the treatment of multidisability clients. Crisler and Settles claimed the results of their efforts show that the "team concept is a viable process that can be implemented to the benefit of both staff morale and client process and outcome" (1979:38).

As was indicated in my third chapter, in the past twenty years, the team concept has been widely discussed in the context of geriatric care. One of the more recent articles

discussing teamwork in this context came from Nate Bottom (1980), director of program development at the University of Alabama. Bottom opened his article with the following remarks:

> At this point in the development of what could be accurately called the health team movement in the United States, it would be a moot point to argue for a team approach to health care. It is to marvel at the various team training programs that have sprung up across the country. It is a "given" that health teams are here and, apparently, here to stay for many years to come (Bottom 1980:100).

Further, in an argument reminiscent of the health team teamwork discussions of the early seventies, Bottom continued

> the team approach challenges the age old concept that the doctor is the captain of the health care ship. The acknowledgement that a patient has needs beyond medical management frequently necessitates a type of rotating leadership on the health team (ibid.).

Some eight years later, however, Sara Qualls and Ruth Czirr of the Interdisciplinary Team Training in Geriatrics program at the Veteran's Administration Medical Center in Palo Alto, California, were less absolute in endorsing empowered team leadership, as they reported a team approach that "went wrong". According to the authors, many conflicts

> stemmed from contradictions among the conceptual models of the disciplines involved. The more these underlying differences in perceptions and beliefs were noticed, the more it was possible to translate and reconcile conflicting opinions and concentrate team energy on patient care . . . (Qualls and Czirr 1988:372).

Thus Qualls and Czirr offer a "modern" reinterpretation of the monitoring theme, which had been prevalent in the positive

teamwork discussions since the late sixties. According to the authors, to better understand teamwork, one can conceptualize different teamwork models as polar opposites arranged on a continuum, with "the most biomedical or acute-care position on one end, the most extremely social or chronic care position on the other, and degrees mixture ranged between the poles" (Qualls and Czirr 1988:373). Each teamwork model, they claimed, has different implications for the logic of problem assessment, the locus of responsibility, the pace of action, the focus of group's attention (i.e., process versus problem), and professional autonomy. In addition, Qualls and Czirr claimed that different teamwork models apply to different health care situations. In conclusion, Qualls and Czirr recommended the use of this conceptual framework for building and maintaining health care teams:

> hopefully, this framework will encourage more formal mapping of well-functioning and poorly functioning teams. . . . Professionals confused or angered by team interactions may profit from the use of curious and non-defensive questions to elicit the implicit model underlying the apparently inexplicable or malicious actions of colleagues from other disciplines (1980:376).

It is only by recognizing that there are a plurality of team concepts, Qualls and Czirr argued, that problems in teamwork can even begin to be resolved.

Some recent authors discussing psychiatric teamwork have also advanced claims concerning leadership and responsibility. In a distinctly Canadian context, Professor Trute of the

School of Social Work at the University of Manitoba and Dr. A.S. MacPherson of the Montreal General Hospital compared psychiatric teams and sports teams in order to arrive at an appropriate model (Trute and MacPherson 1976). Arguing that their "hockey model" best exemplifies teamwork on a psychiatric intake team, Trute and MacPherson added that

> members of a successful hockey team do not quibble over who should do the "skating" or the "shooting". It is the nature of the flow of play patterns in the game that delegates who should pick up the "puck" and to what extent that player should move it (1976:16)

In conclusion, Trute and MacPherson claimed that a "participatory democracy" is best suited to psychiatric teamwork, and that the whole team, rather than the team leader, should be held ultimately responsible for its efforts (ibid.:17). This theme of responsibility would be one point of debate in the recent teamwork writings. Similarly, the members of a British psychiatric team in Derbyshire claimed that there was no need to designate a team leader, since they believed that one would emerge on the basis of personal and professional competence (Johnson et al. 1985). Finally, C.M. McDougall (a professor of medicine) and D.E. Taylor (an instructor in social work) of the University of Calgary restated the team autonomy theme, reminiscent of community health teamwork discussions of the early seventies. McDougall and Taylor claimed that for effective teamwork to occur new organizations of decision making must be implemented in general hospitals which give greater decision making power to

psychiatric teams (McDougall and Taylor 1978; cf. Rubin and Beckhard 1972, Wise 1972).

Finally, there have been several authors who have made positive claims about teamwork in a general health care setting. For example, three authors from the University of Southern California at Los Angeles, Dr. Harold Mazur, Dr. John Beeston and Elizabeth Yerxa (1979), reporting on an educational experiment in interdisciplinary health team care, claimed that task-oriented patient care favoured the learning of team skills (though they added that there was no evidence that better care was given). Similarly, Gloria Engel (1980), Associate Clinical Professor of Community and Family Medicine at the University of Southern California reported that, over the course of working on a team, physicians' assistants began to view other team members (especially nurses) more favourably. Writing in Britain, David McKinlay, a general practitioner in Lancashire, claimed that a team practice, properly managed by the general practitioner, is a superior method of giving care. According to McKinlay, "practices do not manage themselves; they need the type of leadership the GP is best placed to supply" (1989:824). Further, referring to a "leadership continuum" between "autocracy" and "partnership", McKinlay argued that, "the skilled manager will move along this continuum and there may be occasions due to urgency, exclusive knowledge, or legal responsibility, that

may require him to make a decision and then inform the team" (ibid.)

As this brief survey reveals, many recent authors, writing on a variety of team types have continued to advance positive claims regarding teamwork. However, others have argued otherwise. One of the major themes pervading the final period of team concept discussions was the claim, noted in the closing pages of the third chapter, that the health care team is a "myth" or a "fiction".

One version of this claim has been that the idea of teamwork is so vaguely or variously used that it cannot be checked against the reality of health care. In fact, this type of claim had been advanced many years earlier--for example in Bowen, Marler and Androes's (1965) critique of the psychiatric team writings--though it has been made much more frequently since the mid-seventies. Indeed many of the conceptual model arguments noted above have taken cognizance of these team-as-fiction claims, proposing their conceptual models as remedies to the conceptual confusion.

For example, Helena Temkin-Greener (1983:643), of the School of Nursing at the University of Rochester, contended that "no operational definition of [a] team has yet been offered, nor have the characteristics of such a group been adequately described and/or analyzed." Further, in the same article, Temkin-Greener claimed that the discrepancy of the

conceptions of teamwork between nursing and medical staff has serious consequences for evaluation and accountability:

> Whether or not teams are designated as such or simply perceived to exist by department heads, they are never evaluated for their performance as a team. . . Perhaps not surprisingly, no one claims responsibility for a product or service which a team is expected to provide since no one knows what a team is, how it should work, and what its product is (Temkin-Greener 1983:654).

Thus, one version of the team-as-fiction claim denies the existence of teams (and therefore teamwork) because the concept lacks clarity.

However, this version has been less prevalent than the claim that the health team does not exist because teamwork, or some essential aspect of teamwork, does not occur. In the only clear example of a physician advancing this kind of claim, Brian Henderson, the Canadian Medical Association's coordinator of allied medical education and coordinator of the committee on allied health, wrote:

> Anyone who reads the medical or allied health publications must assume that the health care delivery team exists. After all, it's mentioned so frequently. The plain truth is that it doesn't. It never did. It is not difficult to account for the popularity of the team concept, for it implies that qualified individuals are working as an integrated and interrelated whole to ensure essential health care for individuals. But the thread of coordination in the increasingly fragmented agglomeration of health care professions is in terrible jeopardy. (Henderson 1981:83).

According to Henderson, then, because the coordination and integration essential to teamwork is threatened, the health care delivery team does not really exist.

However, the second type of team-as-fiction claim has been most often advanced by nurse authors. One example, is Barbara Given and Sandra Simmons's 1977 article "The Interdisciplinary Health Care Team: Fact or Fiction?". Referring to themes which had been frequently made in the early community health teamwork discussions, Given and Simmons argued that

> ideally, the interdisciplinary patient care team has defined common goals in cooperation with the patient and his family and developed a joint plan of care in which each member makes a unique but complementary contribution to needed services. . . . It is our contention that few interdisciplinary teams now practice in this ideal way (Given and Simmons 1977:166).

Specifically, the authors contended that it has been mainly conflicts over status and individual authority which have obstructed efforts to implement a team approach, especially because these conflicts suppress the recognition (or expression) of expertise. According to Given and Simmons, such conflicts have been especially acute where physicians are involved:

> All members of the health team have traditionally been considered inferior to and under the control of the physician. . . . The nurse for example, may be hesitant to relate independent judgements "upward", may carry out only physician-assigned tasks, and may not effectively participate in decision-making. . . . Even the knowledge obtained from the nurse's continuous contact with the patient may not be given to or sought by the physician (that is, observations not noted or nurse's notes not read) (Given and Simmons 1977:173).

On the issue of authority and decision-making, Given and Simmons concluded that, unless status is equalized or becomes less of a concern for team members, the team approach may not be workable in many settings.

Another team-as-fiction argument was advanced by Lynn McClure of the Leeds Health Authority in the UK (McClure 1984). In her paper, McClure reported the results of a survey which was concerned with respect community nurses' experience of general practice attachment schemes. McClure argued that very few of the attached community nurses or health educators she interviewed perceived themselves as being on a team, defined as "a group of people who make different contributions towards the achievement of a common goal" (1984:71). McClure claimed that nurses' responses "reflected some scepticism, and in a few cases flat denial, in so far as the reality of the primary care team was concerned" (1984:73). Similarly, Ann Bowling, asking why the team approach to health care has been so difficult to implement, argued that even doctors who themselves operated in group practice "are hesitant to experiment with role change or overlap in a broader way" (Bowling 1983:57).

Although sceptical of the existence of the health care team or teamwork, none of the authors advancing this second type of team-as-fiction claim have continued to defend the idea (cf. Rothberg 1981). Indeed, most of these authors have claimed that teamwork in health care, which they typically

depict in terms of collaborative relationships and competence based leadership, is very desirable if not crucial for health care. However, quite a different species of sceptical claims emerged in the late 1970s which doubted claims of either the necessity or the desirability of the approach. What all such arguments have in common is the claim that the team approach has not been adequately evaluated from the point of view of (social) scientific research.

For example, in his review of teamwork in general health care, sociologist Saad Nagi remained uncommitted to the team approach, and noted that adequately controlled evaluative research had not be undertaken on health care teamwork (Nagi 1975; cf. Brown 1982, Temkin-Greener 1983). Similarly, following a review of the studies which had been conducted on rehabilitation teamwork, Dr. Lauro Halstead from the Texas Institute of Research in Rehabilitation and Research, concluded that

> The accumulated material of the past quarter century relating to team care can best be described as a "literature" explosion as opposed to a an "information" explosion. This should not obscure the fact, however, that there are a few good solid studies . . . [which] suggest the overall effects are beneficial. Although these studies serve as a useful guide, the extent to which these findings can be generalized is open to serious question. In the absence of additional research, team care will remain as it is today, largely a matter of faith and the subject of many platitudes (Halstead 1976:511).

More harshly, in their "Twelve Questions about Teams in Health Services", Walter Spitzer (physician-epidemiologist at the Montreal General Hospital), and Rosemary Roberts claimed that

> What evidence there is on all the preceding questions is often irrelevant, frequently feeble. The twelve unanswered questions can be distilled down to this one: are people better off if they are cared for by teams rather than by individuals and if so, under what circumstances is that true? The minimum standard for evaluating the introduction of teams requires the experiment as the basic method and the assessment of health outcomes as dependent variables. (Spitzer and Roberts 1980:4; cf. Appleyard and Maden 1979).

Indeed, during the course of submitting their questions (which, counted separately, numbered well beyond twelve), Spitzer and Roberts expressed scepticism about the definition of a health care team, the rationale of individual insufficiency, the claims of personal patient-centred care, and the claims of the need for educational reform. In short, they doubted the validity of almost all of the major positive claims which had been advanced in previous teamwork discussions.

Finally, following a review of studies of the use of geriatric consultation teams, Schmitt, Farrell and Heinemann of the University of Rochester concluded that "currently, very little is known about the processes and outcomes associated with systematically organized and implemented interdisciplinary team care" (1988:763; cf. Unsigned 1987).[36]

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[36] In the literature review portion of their study of teamwork in the care of diabetics, Feiger and Schmitt (1979) drew a similar conclusion.

In addition to the positive claims regarding teamwork, the scepticism about the existence of the teamwork, and the claims that the supposed benefits of teamwork are scientifically unjustified, there have been other authors who have claimed that teamwork has certain dangers associated with it. Two types of negative claims have been most frequent: claims that teamwork threatens professional autonomy, and claims that teamwork endangers patients' welfare.

One of the first claims that teamwork threatened professional autonomy appeared in Favis's (1978) letter to the editor in the American Journal of Psychiatry, headed "Psychopathology of the Team Concept". Favis, a psychiatrist working in New York State, argued that "the treatment team, which should be or once was a useful treatment modality in psychiatry, has been misused, distorted, and politically exploited" (Favis 1978:1117). According to Favis, a New York state law which officially recognized non-psychiatric team leaders, posed the greatest threat.

> There are many ways in which the team can become pathologic. The psychiatrist may merge imperceptibly with the treatment team and lose his identity. When this happens, the psychiatrist can no longer function to monitor psychiatric treatment. . . . The psychiatrist's or ward physician's supervisory role has been blurred by the addition of the team leader and lay administrator. This has weakened and confused the physician's supervisory role. Is this a political manoeuvre on the part of the paramedical workers to gain control of and power in the mental health field? (Favis 1978:1117).

Conversely, Favis argued, an overly dominant psychiatrist would stifle the initiative of other team members. To prevent this, Favis argued, the psychiatrist should have another psychiatrist or physician available for consultation. In conclusion, Favis demanded that the state law be revised or revoked and that team members roles be redefined.

Ten years later, another psychiatrist in New York state, Irving Jabitsky (1988) advanced similar claims and concerns about the state law. Drawing on most of the psychiatric team literature cited in this thesis, including Favis's letter, Jabitsky criticized the egalitarian view of decision-making on psychiatric teams. Claiming that "the proliferation of professionals is a challenge to the psychiatrist's professional identity", Jabitsky added

> The area of greatest confusion and intrateam conflict is the failure of members to link the psychiatrist's authority with his legal responsibility by questioning his expertise. . . Almost everyone recognizes the legal responsibility of the psychiatrist in making decisions regarding admissions, discharges, legal status, passes and medication. Yet the psychiatric team often challenges the authority of the psychiatrist to make those decisions (Jabitsky 1988).

According to Jabitsky, two consequence of this team approach were a drop in enrolment in psychiatry programs and an exodus of psychiatric professionals from the New York region. Some of the solutions Jabitsky recommended to the problem were to change the status of "team leader" to "administrative assistant", to give the psychiatrist management status, and,

in general, to give psychiatrists the "authority that society usually assigns to them" (1988:580).

A similar, lengthy critique was offered by James Appleyard and J.G. Maden (1979), two British physicians. Their remarks were directed to National Health Service and the Department of Health and Social Security regulations, which Appleyard and Maden said called for "team decisions" on matters of patient care, and proposals from the same bodies for multidisciplinary review boards which would review psychiatric teams' activities. Appleyard and Maden argued that both the regulations and the proposals threatened the autonomy of physicians. In their words, "we see this as clinical direction by the hospital authorities- a dangerous development" (Appleyard and Maden 1979:1306). Appleyard and Maden concluded that "individual members have specific statutory responsibilities, which they should carry out despite what the majority of the team may think" (ibid.:1307; cf. Henderson 1981a, 1981b).

In another recent claim bearing on the question of professional autonomy, Joan Bloom of the University of California and Jeffrey Alexander of the American Hospital Association reported a study on team nursing. According to these authors, at least in larger facilities and in cases where nurses have not developed external professional ties, team nursing is better described as bureaucratic control than as professional coordination (Bloom and Alexander 1982).

In addition to advancing claims that teamwork threatens professional identity and autonomy, all the above critics have also claimed that this has further detrimental consequences for patient welfare by obstructing the exercise of professional competence and expertise. Other authors have made the claim that teamwork is harmful to patient welfare their only concern.

For example, Edmund Erde (1981), Associate Professor at the Institute for the Medical Humanities at the University of Texas argued that the undue development of loyalty to the team distracts team members from their loyalty to the patient, which he argued should be their prime concern. More specifically, Erde contended that, in the process of teamwork, certain "social norms" develop (e.g., that team members must support each other in public) which may be in conflict with "moral norms" (e.g., "whistleblowing" on team members who violate the interests of the patient). Further, Erde claimed, the team concept may be inapplicable to the process of health care (cf. Jabitsky 1988). In contrast, Ruth Purtilo (1988), ethicist-in-residence at the Massachusetts General Hospital, claimed that a greater teamwork danger lies in team members devoting too much of their efforts toward professional autonomy from the team, without due consideration for the effects of their actions on the patient. Unlike Erde, Purtilo did not claim that the team concept is inapplicable to health care; however, she did urge the development of ethical

guidelines and moral decision-making methods for use in team care.

In sum, the most recent period in the history of teamwork has been characterized by perhaps an even greater variety of claims than the preceding era. Despite this variety, the claims fall into four loose schools of thought. (1)positive claims, affirming the reality, validity and desirability of a team approach to health care; (2)sceptical claims which consider the idea of a health team to be a fiction or a myth, but which consider the ideal of teamwork to be valid; (3)sceptical claims, which have not denied the reality of the health care team, but which have suspended judgement on the desirability of a team approach to care; and (4)negative or critical claims, which have argued that there are certain dangers inherent in teamwork. Positive claims have affirmed the value of a team approach, though some difficulties in implementing have been reported. Two common claims of this type have argued the value of developing either clear conceptual models for understanding teamwork or information sharing technology (e.g., the POR system) for integrating team members efforts. In general, authors who have advanced positive teamwork claims have viewed teamwork in terms similar to the 1960s themes of competence-based leadership, collaboration, and attention to group process- though some have added that the nature of teamwork may vary under different conditions or patient problems. Sceptical authors

who have claimed that the team is a fiction or a myth have sometimes argued that the team concept is too unclear to be verified. More often, though, this type of claim has held that the ideal of teamwork is clear enough, but that it simply is not being realized. Still other sceptical authors have acknowledged the reality of the teamwork, but have questioned its validity as an approach to health care. In making their claims, these authors have usually referred to standards of social scientific research which, they have argued, are not adhered to in others' claims of the validity of teamwork. Finally, critics of teamwork have also acknowledged the reality of teamwork, but, going further than the second type of sceptical authors, they have argued that teamwork poses threats either to professional autonomy and/or patient welfare.

In terms of professional affiliation, this final era has also seen the emergence of a new group contributing to the discussions, namely academics. Indeed, in recent years, the team concept has largely become, the descriptive sense of the term, an "academic topic" [1]

Furthermore, as with other periods in the history of the team concept, the claims have differed according to professional affiliation. Nurses, for example have most often

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[1] In analyzing the claims by professional group, I have considered some authors as being both academics and belonging to one of the other professional groups, according to the author affiliation information provided.

advanced the claim that the team is a myth, but that teamwork -usually seen as a collaborative enterprise- remains an ideal to be approached. Non-psychiatric physicians have also often made this type of claim, though they have often characterized teamwork in terms of planning, coordination and/or formalized communication. Other non-psychiatric physicians, however, have expressed scepticism regarding the value of teamwork. Recent psychiatric authors have been uniformly critical of teamwork usually claiming that it leads to a loss of professional identity or autonomy which they have argued endangers patient welfare. The claims of academic authors have been divided between those who have argued that the teamwork is a viable approach to health care and those who have expressed scepticism regarding its validity.

Finally, two remarks may be offered regarding the "geography" of the team concept. First, in terms of national differences, it has only been authors from Canada, Britain, and New York state who have claimed that teamwork poses a threat for professional autonomy. In each case, many of their criticisms have been directed at government bodies, who they have claimed is imposing the team concept on health care without due consideration of its validity.

Second, this final period saw the emergence of a new centre of teamwork writings, at the University of Rochester in New York. (Indeed, New York itself has been a common source of teamwork claims.) One author who published out of the

University was Theodore Brown (1982) whose historical-ideological analysis of the team concept was presented at the outset of my thesis. The articles by Feiger and Schmitt (1979), Temkin-Greener (1983) and Schmitt, Farrell and Heinemann have also originated from the University of Rochester. All these contributions have shared the general character of being either sceptical or critical of the team concept.

VI. SUMMARY, DISCUSSION AND CONCLUSIONS

The "team" concept has held a considerable and continuing interest for health care authors, and has had a long and complex history. In this thesis I have traced the major themes and contributors to the discussions, from Barker's 1922 address to some of the most recent writings on the topic.

Given the vast and lengthy literature, it is odd that there have been very few historical treatments of the subject. Moreover, with the partial exception of Brown's historical-ideological analysis of "team talk", there have been no attempts to view the literature in social constructionist fashion as a body of claims. By using this perspective in a historical fashion, this thesis has attempted to fill that void.

In adopting this perspective I have not endeavoured to determine the "objective validity", the "correct" definition, or the value of the team concept. Instead, I have concerned myself with the subjective life of the concept, examining what authors have claimed about it, and how their claims have varied over time or according to professional groups and nations. Consequently, this thesis has yielded insights which could not be arrived at by other sociological approaches.

A. Possible Limitations to this Study

Before re-presenting some of these insights, it may be appropriate to acknowledge some of the possible limitations to the method and perspective used here.

The first possible limitation concerns the "TEAM*" search term I used to locate team concept documents. Using this procedure might have excluded documents which, from the claimants' points of view, were relevant to the topic, simply because they did not use the "TEAM*" term in their title.[38] However, as I indicated in my methods chapter, even with this exclusion, the sample of documents covered a long time period and came from many sources. Further, the systematic nature of the exclusions would assist future researchers in locating and examining excluded documents, in order to determine how far my insights could be generalized. (Similar remarks apply to the other exclusions made in sampling the literature.) One possible consequence of this exclusion might have been an exaggeration of the non-cumulative appearance of the discussions (see below). As compared to the results of other social constructionist research, the claims about the team concept presented in this thesis have been more indicative of assertions on "parallel lines" rather than authors directly engaging each other in dialogue. To what extent this is actually the character of the team concept literature in

[38]For example, only 15 of the 80 reference sources in Crawshaw and Key's (1961) review of psychiatric teams were used to locate older documents.

general or a function of the sampling procedure I have used is a question which only future research could answer.

One objection which the reader may have to the perspective adopted here, which I mentioned in my second chapter, concerns one aspect of what Woolgar and Pawluch (1985) have called "ontological gerrymandering". According to these and other authors, one source of "tension" in constructionist research consists in the researcher regarding one aspect of social reality (e.g., "teamwork") with an attitude of agnosticism while other explanatory conditions (e.g., an author's nationality or professional identity) are not so regarded.

However, I have argued above that the researcher need not regard these "conditions" as objective. The important point is that the claimants whose accounts the researcher examines have not considered these conditions as problematic or in need of discussion or debate (cf. Gusfield 1986). What are assumed to be objective are the claims themselves.

Further, I do not regard social constructionism as an explanatory paradigm, which would involve some attribution of objective causes, but an interpretive methodological perspective. As such, the social constructionist researcher can consider if or how some part of social reality ("teamwork") has varied across other socially constructed conditions (e.g., "nationality"). The crucial matter is that, in order to gain insights about the subjective side of social

reality, the researcher remain agnostic regarding the construction which claimants themselves regard as problematic. That is what I have endeavoured to do here.

With these limitations in mind, I offer in the remainder of this concluding chapter the most general statements about how the team concept has been discussed by health care writers. To provide a general context, I begin with some remarks about the literature as a whole. Following this, I summarize some of the main historical, national and professional differences in how claims have been made. Finally, I present what has been perhaps the least challenged claims about the team concept, and consider the nature of recent re-evaluations.

B. General Remarks about the Literature

Two remarks may be made about the literature as a whole. First, while reviewing document bibliographies to reconstruct the "TEAM*" literature from before 1966, it became apparent that the literature is quite non-cumulative. In other words, when later authors dealt with the team concept, they did not usually cite earlier authors. Instead, the later authors typically made remarks like "there has been a lot of talk these days about the need for teamwork in health care." This non-cumulative character is also true for citations between countries. For example, the earliest articles from Canada and Britain made no explicit reference to the earlier American

writings or vice versa."[39] A similar observation applies to discussions of the different types of health care teams. For example, authors describing nursing teams rarely refer to clinic teams (or vice versa). In this sense, then, the early team concepts were constructed in isolation from each other.

Another general remark about the literature concerns authorship. With few exceptions, the claims have not been advanced by teams, but about teams. This becomes clear upon comparing the positions of the authors to the list of team members provided by the authors. In most cases where such information is given there are discrepancies between these two lists.[40] Many of the claims about the team concept have been made by sole authors. Others have been submitted by professionals who were not designated as team members (e.g., administrative personnel or, more recently, academics) or by

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[39]The eventual exception to this example was Brooks (1973), a Canadian author publishing in Britain, who made direct references to the articles by Beloff and his associates (Beloff and Willet 1968; Beloff and Korper 1972). Also, Wise (1972), in his history of health teams published in the U.S., showed a strong cosmopolitan interest, citing earlier instances of the team approach in Britain, South Africa, Israel and the U.S.

[40]The possible exceptions to this observation are the articles on the nursing team by Calabrese et al. (1953) and the Nursing Staff of the VA Hospital, Bronx (1953); the discussion of the psychiatrist and the social worker as a psychiatric intake team by Weinberger and Gay (1949) and several of the articles on the British community health team (Beven et al. 1980; Fry, Dillane and Connolly 1965; Hasler et al. 1968; Johnson et al. 1985). Lesser's (1955) discussion of the psychiatric team also lists a number of co-authors in a footnote, though their positions are not given.

team leaders. In this sense, then, the team concept largely has not been a team product.

C. Historical Differences

Before considering national and professional differences in team concept claims, it may be useful to summarize the broad historical changes which have occurred.

In claiming what constitutes a health care team, authors have offered a variety of definitions. In the first period of teamwork history authors reported teams in the context of general practice, hospital, nursing, and psychiatry. With the coming of the fifties, rehabilitation teams were also reported. Beginning in the late sixties, authors discussed teams in community and home settings, and writing about condition- and population-specific teams arose. Recent authors have continued to address these team types, though some have argued that the idea of a health team is a fictitious one. Amidst this variety, the most common claim has been that a team is 'a group of people working towards a common goal'. More often, authors have defined a team by referring to the process of teamwork.

Claims about what constitutes teamwork have also changed over time, though four fairly distinct periods have been apparent. The first writings on teamwork introduced the themes of (1)the sharing, coordination and integration of information; (2)planning, supervision and leadership; (3)specialization and the growth of knowledge, and the

individual insufficiency thesis; (3)the recognition of team member expertise; (4)the comprehensive nature of team diagnosis or patient care; and (5)professional growth as resulting from a team approach.

Since the first period of teamwork history, several additional themes have been presented and reinterpretations of former themes have taken place. First, in the transition from the first to the second era, there was a movement from claims that teamwork involves a structured approach to claims that teams are flexible and adaptable entities. In this context, authors first extensively presented themes of the monitoring, role-definition, and integrative processes of teamwork. Next, in the transition to the third phase, there was a movement away from claiming that the team is physician led to new ideas of leadership. In this context, the themes of egalitarianism, professional development, and democratic or competence-based leadership either emerged or were more fully developed than earlier versions. In the third era, there was also a renewed concern for educational reform, communication and group dynamics, all of which were seen as necessary for effective teamwork. Finally, in the transition to the final period, there was also a movement from positive claims to sceptical or critical views of teamwork (though positive claims continued to appear). In this setting, claims that the team approach was a myth, scientifically unfounded, or even dangerous emerged.

Thus there have been considerable changes over time in the nature of teamwork concept claims. However, these transitions have not meant a displacement of earlier by later themes. Indeed, taking a larger view of the discussions, it appears that there has been an accumulation and proliferation of teamwork issues which, from the point of view of the most recent claimants, have not been resolved.

D. Geographical Differences

Perhaps the most noticeable geographical difference in the claims is a chronological one. The first discussions emerged in the United States, in the writings of Barker (1922), Rogers (1932), Hutt, Menninger, and O'Keefe (1947), and Ackerly (1947). Indeed, this area has been the most frequent source of team concept claims. Writings from Canada or Britain did not appear until the mid-1960s, with the discussions of community health teams by Menzies (1965) and Fry, Dillane and Connolly (1965).

The American literature has also shown a much greater variety of team types. In fact, all the types which have been discussed in the literature have appeared in U.S. contributions, whereas only general practice and psychiatric teams have been extensively discussed in the British literature. (Canadian authors have also given some attention to hospital teams.)

In terms of teamwork themes, one major geographical difference has concerned the claim that the government

threatens team or professional autonomy. This type of claim has been limited to the writings from Canada, Britain and New York. Other American authors have addressed the autonomy issue, but their concerns have only been for the autonomy of the team from the larger institution in which it operates. As another national difference in teamwork claims, the arguments for egalitarian or competence-based leadership (at least during the third period) have been confined to North America. Finally, although a number of recommendations for educational reform have come from the U.S. and Canada, these types of claims have be absent in the British literature.

There have been several U.S. and Canadian nuclei for team concept discussions. In the early writings, several writings were associated with the Menninger Clinic in Topeka, Kansas. The clinic was associated with the works of Hutt, Menninger and O'Keefe (1947), and Modlin and his colleagues (Modlin and Faris 1954, 1956; Modlin, Gardner and Faris 1958). Further, Peplau (1953) regarded the Menninger Clinic as a model for how teamwork should be conducted Authors from this centre were especially concerned with role-definition and the adaptability and integration of the team.

Two centres which appeared in the second and third eras were the Dr. Martin Luther King Jr. Health Centre (MLK) and Montefiore Hospital, which were associated with each other and with many team concept authors. Both George Silver (Silver 1958; Silver and Stiber 1957) and Minna Field (1955) were

associated with the Montefiore. Later, Harold Wise (1972), the director of the MLK, considered the Montefiore as a prototype for his own work. Later still, Tichy (1974), noted that the MLK was responsible for the development of the Montefiore's Institute for Health Team Development. Further, according to Wise, Richard Beckhard and Irwin Rubin (Beckhard 1972; Rubin and Beckhard 1972) had been contracted from the Massachusetts Institute of Technology. In general, the writings from or about the MLK and the Montefiore have been optimistic about teamwork, even though they argued that it poses some difficulties in practice. In particular, the MLK authors have contributed considerably to the claims of competence-based management, team autonomy, and the preventive approach of team care.

Even the sceptics and the critics of the team approach have regarded the MLK as something of a barometer of the team concept. For instance, in claiming that the concept is scientifically unfounded, Spitzer and Roberts noted that "even the work considered the classic in the area, that of Wise, Beckhard, Rubin and Kyte acknowledges that no valid measures exist which demonstrate that patients receive better care from a more effective team than from a less effective one or from an individual" (1980:4). Further, in his critical history, Brown (1972) turned to Wise for an indication that a re-evaluation of the team concept was taking place. Brown cited Wise as saying "Physicians are more important than other team-

members--we do not disagree with them; we wait for them to lead" (in Brown 1982:17).

A major source for recent U.S. contributions has been the University of Rochester, also in New York. The University has been associated with the works of Feiger and Schmitt (1979), Brown (1982), Temkin-Greener (1983), and Schmitt, Farrell and Heinemann (1988).[41] Authors from this University have generally advanced critical or sceptical claims.

Finally, several Canadian articles were submitted from the University of British Columbia, especially during the third period. The writings of Baumgart (1968), McCreary (1968), and Szasz (1970) contributed significantly to the discussions of educational reforms. Beattie and Crawshaw (1975), also from the University, claimed the importance of the problem-oriented record system for teamwork. All these writers have consistently advanced positive claims about the validity of the team approach.

E. Professional Differences

Over the history of the team concept, one major difference in how teams and teamwork have been constructed has been according to professional group. While there has been considerable overlap between professional groups in terms of the claims advanced, and while there have been differences

[41]The University of Rochester was also the source of the early study of Bates and Kern (1967), which the authors described as an attempt to determine the "critical requirements" of nurse-physician behaviour.

within these groups over time, several claims-making patterns among professional groups have emerged in the course of my research.

Nurses and other non-medical professionals, who have been the major contributors to the team concept discussions, have typically claimed that in general health care and psychiatric care teamwork implies a process of role-definition, communication, self-monitoring and team integration; the recognition of expertise; and collaboration and competency-based leadership. For most of the history of the team concept, non-medical claims have been positive. However, the most recent era has seen some changes, with nurses usually claiming that the team is a fiction while other non-medical authors being more mixed in their views.

In contrast to other nurse authors, though, nurses writing about team nursing have typically claimed that teamwork involves planning, role-definition and role-differentiation, delegation, supervision and professional leadership. (As one exception to this generalization, team nursing discussions during the fifties defined teamwork more in terms of democratic leadership and collaboration.)

Medical team concept authors, especially in recent years, have been in the minority. They also have typically constructed the team concept quite differently from non-medical authors. However, even within medicine itself, there have been differences in the types of claims made.

Most non-psychiatric (and later psychiatric) physicians have argued that teamwork involves formal caregiving roles; physician leadership, coordination or decision-making; information sharing and problem solving; and delegation. Recent physician claims that the team is a myth, or that teamwork remains a viable and desirable approach, have referred to these same themes. However, in the community health team writings of the of the late sixties and early seventies, physicians' views of teamwork were very similar to non-medical authors.

Early psychiatric (and particularly orthopsychiatric) physician writers advanced a different version of teamwork. These early writers often claimed that teamwork necessitated a considerable amount of informal communication and self-monitoring, aimed at developing an integrated team and a team identification. More recent psychiatric claims, however, have construed teamwork primarily as a problem-solving process, eschewing the idea of a self-monitoring team. Moreover, psychiatric authors were the first to express sceptical or critical views, beginning in the early sixties, and have contributed significantly to the recent critique of teamwork. In particular, they have contributed to the recent argument that teamwork poses a threat to professional identity or autonomy and to patient welfare. Later psychiatric claims have also criticized the egalitarian view of teamwork, sometimes arguing that because teamwork often results in

"pathological" group processes physician leadership is crucial.

Articles from the first three eras of teamwork history typically came from authors working at health care facilities. However, one final professional group, which has only recently emerged as a major contributor to the discussions, is academia. Academic's views have been divided between those authors who have claimed that the team approach is viable and those who have claimed it is scientifically unfounded.

F. A Final Word

In almost seventy years of team concept writing, there has been an incredible variety of claims advanced and challenges levelled against these. Perhaps the least challenged view has been:

> (1)that the team is a group of health care personnel working towards a common goal;
>
> (2)that teamwork implies team members frequently sharing information, contributing the expertise that they possess, and recognizing the expertise of others; and
>
> (3)that the team approach provides comprehensive care.

To say that this has been the "least challenged view", though, is not to say that these qualities have been universally attributed to teamwork. In addition, as much as the claim of "comprehensive care" has been equated with "better care", it has been challenged as well. What is more, in what roughly corresponds to Brown's (1982) re-evaluation phase of teamwork

history, almost every other claim about the team concept has been challenged and debated.

Thus, as much as he refers to the literature on the subject, Brown is quite correct in concluding that recent years have seen a re-evaluation of the team concept. Some qualifications apply to this conclusion, though. For one thing, many authors have continued to espouse the validity of the team concept. For another, the re-evaluation has not been a uniform process.

In fact, judging by the recent claims which have been advanced, there have been at least <u>two</u> re-evaluations. On the one hand, some claimants have contended that the ideals of teamwork are desirable, but that there is not, or never has been, a health care team based on these ideals. The major debate here has been what is implied by teamwork. On the other hand, other re-evaluators have argued that the necessity or desirability of a teamwork is a matter of debate, especially because there is a paucity of solid scientific evidence of its superiority. These authors have not questioned the existence of health care teams, but have only doubted their desirability.

The basic disagreement, then, has been between those authors who have claimed that the greatest need is for implementing a team approach and those authors who have claimed that it is more important to cautiously evaluate whether such an approach is merited. For one group, the

problem is that the team approach has never been tried. For the other, the problem is that it has never been tested. At present, it seems that neither group is satisfied.

APPENDIX:

Considerations for Future Research

As was indicated my method chapter, there is an enormous literature on the team concept. Thus, the present research should be regarded as something of a beginning understanding of how the team concept has been discussed in health care. In spite of the large number of documents which were examined in preparing this thesis, there is much room for further exploratory research on the topic. In particular, future research could be helpful for determining how or to what extent my findings and interpretations could be generalized.

For example, one could study the use of the concept in other health care contexts which were excluded from my study, e.g., in teaching, research, dentistry or surgery. In particular, one could examine the claims advanced in the context of condition-specific teams (e.g., in the context of stroke or diabetes) which were largely excluded in my quest for general discussions of the team concept.

More generally, there is the matter of constructions which authors appear to view as synonymous with, or related to, the team concept. While undertaking my research, I noted that many authors associated the team concept with such terms as e.g. "patient-centred care", "problem-centred care",

"attachment", "coordinated care", "comprehensive care". Although a beginning has been made towards understanding how authors have connected these alternative expressions with the team concept, much work remains to be done in clarifying these connections. In following this line of research, one could attempt to derive from authors' accounts a conceptual map of constructions related to the team concept.

Still another fruitful approach to the topic could be to investigate the construction of the team concept in a "natural" health care setting, such as a clinic or hospital which claims to use such an approach. In such settings, one could explore what team concept themes emerge and how they compare with those discovered here.

Another profitable avenue for future research could be a network approach to the literature. Using this approach, one could explore whether there has been a diffusion of the team concept across professional groups, countries, team types or other categories which such exploratory research found to be relevant. This type of research could also determine, in a more complete and systematic way than has been possible here, whether there have been key writers or locations, or schools of thought about the team concept. (Given the apparent diffuseness in the team concept documents from before the mid-1960s, it would seem advisable to concentrate on more recent documents.)

Lastly, one could compare the findings of the present study, or any/all the above approaches, to the use of the team concept in other organizational contexts where the language is used (e.g., business, politics). While doing this research, I was sensitized to the use of the team concept and found it discussed virtually everywhere, suggesting that there is at least a substantial data base to pursue this line of research in other organizational contexts.

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